SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Livtencity™ (maribavir)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- ❑ Member is 12 years of age or older
- ❑ Prescribed by or in consultation with a specialist, or being followed up by multidisciplinary transplant team
- ❑ Member weighs at least 35 kilogram (kg) or greater
- ❑ Member is a recipient of a hematopoietic stem cell or solid organ transplant

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- ❑ Member has documented cytomegalovirus (CMV) infection in whole blood or plasma **(screening value ≥ 2,730 IU/mL in whole blood or ≥ 910 IU/mL in plasma)** in 2 consecutive assessments separated by ≥ 1 day
- ❑ Member has current CMV infection that is refractory **(documented failure to achieve > 1 log10 decrease in CMV deoxyribonucleic acid [DNA] level in whole blood or plasma after ≥ 14 days of treatment)** to anti-CMV treatment agents (e.g., ganciclovir, valganciclovir, cidofovir, or foscarnet), despite documented genetic mutations associated with resistance
- ❑ Medication will **NOT** be co-administered with ganciclovir or valganciclovir
- ❑ Member will be monitored for clinically important drug interactions that could result in decreased therapeutic effect of requested medication

Reauthorization: 6 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member must have disease improvement and/or stabilization **OR** improvement in the slope of decline **(> 1 log10 decrease in CMV DNA level in whole blood or plasma after 14 days or longer treatment)**
- ❑ Member continues to exhibit symptomology of CMV disease/syndrome
- ❑ Provider is **NOT** attempting to continue therapy for prophylaxis treatment
- ❑ Member has **NOT** experienced any treatment-restricting adverse effects (e.g., dysgeusia, diarrhea, nausea, and recurrence of underlying disease)
- ❑ Member is **NOT** a non-responder (resistant) to requested medication

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*