SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL 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 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

Drug Requested: Prevymis® (letermovir) **Injection for IV Infusion (J3490) (Medical)**

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:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

Weight (if applicable): _____ **Date weight obtained:** _____

☐ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Quantity Limit (max daily dose) [NDC/HCPCS Unit]:

- 480 mg/24 mL solution per 1 vial; NDC 00006-5004-##; 1 billable unit per day
- 240 mg/12 mL solution per 1 vial; NDC 00006-5003-##; 1 billable unit per day

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.

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❑ Diagnosis: Cytomegalovirus, prophylaxis in hematopoietic cell transplant recipients

Initiate therapy between Day 0 and Day 28 post-HSCT (before or after engraftment) and continue through Day 100 post-HSCT. In patients at risk for late CMV infection and disease, Prevymis® may be continued through Day 200 post-HSCT.

Recommended Dosage:

- **Adult and Pediatric Patients 12 Years of Age and Older and Weighing at least 30 kg:** 480 mg administered intravenously once daily
- **Pediatric Patients 6 Months to Less than 12 Years of Age or 12 Years of Age and Older and Weighing Less than 30 kg:**

Body Weight	Daily IV Dose
30 kg and above	480 mg
15 kg to less than 30 kg	120 mg
7.5 kg to less than 15 kg	60 mg
6 kg to less than 7.5 kg	40 mg

Length of Authorization: 200 days of therapy

- ❑ Member is 6 months of age or older and weighs at least 6 kg
- ❑ Member will be receiving Prevymis® for the prophylaxis of cytomegalovirus (CMV) disease
- ❑ Member is a CMV-seropositive recipient [R+] of an allogeneic hematopoietic stem cell transplant (HSCT)
- ❑ Medication will be initiated between day 0 and day 28, before or after engraftment
  - Enter date transplant was performed: _____
- ❑ Member is **NOT** receiving the requested medication beyond 200 days post-transplantation
- ❑ Provider must submit chart notes to document contraindication to therapy with oral Prevymis® tablets and rationale for medical necessity to continue IV Prevymis® therapy

❑ Diagnosis: Cytomegalovirus, prophylaxis in kidney transplant recipients

Initiate therapy between Day 0 and Day 7 post-transplant and continue through Day 200 post-transplant.

Recommended Dosage:

- **Adult and Pediatric Patients 12 Years of Age and Older and Weighing at least 40 kg:** 480 mg administered intravenously once daily

Length of Authorization: 200 days of therapy

- ❑ Member is 12 years of age or older and weighs at least 40 kg

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- ❑ Member will be receiving a kidney transplant
- ❑ Member will be receiving Prevymis® for the prophylaxis of cytomegalovirus (CMV) disease
- ❑ Member is at high-risk for CMV disease [documentation recording kidney donor is CMV-seropositive, and the recipient (member) is CMV-seronegative (D+/R-)]
- ❑ Medication will be initiated between day 0 and day 7, before or after engraftment
  - Enter date transplant was performed: _____
- ❑ Member is **NOT** receiving the requested medication beyond 200 days post-transplantation
- ❑ Provider must submit chart notes to document contraindication to therapy with oral Prevymis® tablets and rationale for medical necessity to continue IV Prevymis® therapy

Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy – Proprium Rx**

For urgent reviews: Practitioner should call Sentara Health Plans Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health Plan's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****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.****