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Letermovir (Prevymis™)
Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
_____	_____	_____	**Specify:** _____

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient and MAY AFFECT THE OUTCOME of this request.

Prior authorization is required for oral letermovir. Requests for intravenous letermovir should be directed to the member's medical benefit. Payment will be considered under the following conditions:

1) **Medication is to be used for the prophylaxis of cytomegalovirus (CMV) infection and disease; and**
2) **Patient or donor is CMV-seropositive R+ (attach documentation); and**
3) **Patient has received an allogenic hematopoietic stem cell transplant (HSCT) within the last 28 days (provide date patient received HSCT); and**
4) **Is prescribed by or in consultation with a hematologist, oncologist, infectious disease or transplant specialist; and**
5) **Patient is 18 years of age or older; and**
6) **Dose does not exceed:**
   a) **240mg once daily when co-administered with cyclosporine**
   b) **480 mg once daily; and**
7) **Patient must not be taking the following medications:**
   a) **pimozide; or**
   b) **ergot alkaloids (e.g., ergotamine, dihydroergotamine); or**
   c) **rifampin; or**
   d) **atorvastatin, lovastatin, pitavastatin, simvastatin, or repaglinide when co-administered with cyclosporine; and**
8) **Patient does not have severe (Child-Pugh Class C) hepatic impairment (provide score); and**
9) **Therapy duration will not exceed 100 days post- transplantation.**

Is patient or donor CMV-seropositive R+? ☐ **Yes (attach documentation)** ☐ **No**
Has patient received HSCT within the last 28 days? ☐ **Yes; date**_____ ☐ **No**

Prescriber specialty: ☐ **Hematologist** ☐ **Oncologist** ☐ **Infectious Disease Specialist** ☐ **Transplant Specialist**

☐ **Other (specify and provide consultation with one of the above specialists):**_____

Consultation date:_____ **Physician name, phone & specialty**:_____

Will letermovir be co-administered with cyclosporine?

☐ **Yes; dose does not exceed 240mg once daily**

☐ **No; dose does not exceed 480mg once daily**

Does patient have concurrent therapy with any of the following? ☐ Yes ☐ No

- **Pimozide; or**
- **Ergot alkaloids (e.g., ergotamine, dihydroergotamine); or**
- **Rifampin; or**
- **Atorvastatin, lovastatin, pitavastatin, simvastatin, or repaglinide with co-administered with cyclosporine**

Does patient have severe (Child-Pugh Class C) hepatic impairment (provide score)?

☐ **Yes** ☐ **No** Score:_____

Is patient established on medication?

☐ **Yes; provide therapy start date**:_____

☐ **No**

Attach lab results and other documentation as necessary.

9. PHYSICIAN SIGNATURE

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.