

# OPTIMA FAMILY CARE MEDALLION 4.0

## PHARMACY/MEDICAL PRIOR AUTHORIZATION 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. Incomplete form will delay authorization process.

**Drug Requested:** Prevmis® (letermovir) Tablets (Pharmacy)

**DRUG INFORMATION:** Complete all information below or authorization process will be delayed.

Drug Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

**Recommended dose:** 480 mg tablets once daily. Therapy is started between Day 0 and Day 28 post-transplantation (before or after engraftment), and continue through Day 100 post-transplantation.

*Prevmis® is contraindicated in members receiving pimozide, ergot alkaloids, or cyclosporine in conjunction with either pitavastatin or simvastatin.*

**CLINICAL CRITERIA:** The following criteria **MUST** be met and boxes **must** be checked to qualify or authorization process will be delayed.

To receive approval through Day 100 post-transplantation for this drug, the following questions **MUST** be completed.

1. Is member 18 ≥ years of age  Yes  No
2. Is member using this for prophylaxis of cytomegalovirus (CMV) infection and disease in adult CMV-seropositive recipients [R+] of an allogeneic hematopoietic stem cell transplant (HSCT)?  Yes  No
3. Is member taking pimozide, ergot alkaloids, or cyclosporine in conjunction with either pitavastatin or simvastatin?  Yes  No

**Medication being provided by (check applicable box below):**

Physician's office

**OR**

Specialty Pharmacy:

For Optima Commercial Members:

PropriumRx Pharmacy

For Optima Family Care Members:

Sentara Norfolk General CM Pharmacy

**\*\*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.\***

Patient Name: \_\_\_\_\_

Member Optima #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

DEA OR NPI #: \_\_\_\_\_

\*Approved by the Pharmacy and Therapeutics Committee: 2/15/2018

REVISED/UPDATED: 7/1/2018