OPTIMA HEALTH FAMILY CARE

(MEDICAID)

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 1-844-723-2094**. 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: Prevymis® (letermovir) **Injection for IV Infusion (J3490) (Medical)**

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 IV once daily. Therapy is started between Day 0 and Day 28 post-transplantation (before or after engraftment), and continue through Day 100 post-transplantation.

Prevymis® 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 to ensure authorization will **NOT** 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):

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

NPI or DEA # of administering location: _____

OR

❑ **Specialty Pharmacy :** ❑ **PropriumRx** **OR** ❑ **Sentara Norfolk General CM Pharmacy**

(Continued on next page; signature page MUST be attached to this request.)

(Signature page MUST be included with this request.)

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 Pharmacy and Therapeutics Committee:** 2/15/2018
REVISED/UPDATED: ~~6/21/2018;8/29/2018; 10/8/2018;~~ **(REFORMATTED) 2/6/2019**