

OPTIMA HEALTH COMMUNITY 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 1-844-348-3720**. 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) 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.

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 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