

**OPTIMA HEALTH COMMUNITY CARE  
AND  
OPTIMA FAMILY CARE  
(MEDICAID)**

**PHARMACY 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 1-800-750-9692.** 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® (Ietermovir) 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 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):**

- Physician's office    **OR**     Specialty Pharmacy -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 the Pharmacy and Therapeutics Committee: 2/15/2018

REVISED/UPDATED: 6/21/2018; 8/29/2018