OPTIMA HEALTH COMMUNITY CARE
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 1-800-319-5003. 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) **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.**

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 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 a Specialty Pharmacy (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: 6/21/2018