OPTIMA HEALTH PLAN

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 1-844-202-5034. 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 started between Day 0 and Day 28 post transplantation (before or after engraftment), and continue through Day 100 post-transplantation.

CLINICAL CRITERIA*: *The following criteria MUST be met. ALL boxes must be checked to qualify or authorization process will be delayed. IF medical chart notes or lab results need to be submitted with this request, it needs to be stated here.

- ❑ Patient is ≥ 18 years of age

AND

- ❑ Patient is receiving this treatment for prophylaxis of cytomegalovirus (CMV) infection and disease

AND

- ❑ Patient is a CMV-seropositive recipient [R+] of an allogeneic hematopoietic stem cell transplant (HSCT)

AND

- ❑ The medication will be initiated between day 0 and day 28, before or after engraftment
  - Enter date transplant was performed _____

AND

- ❑ Patient is not receiving the medication beyond 100 days post-transplant

AND

- ❑ Medical chart notes **MUST** be submitted to document contraindication to therapy with oral Prevymis tablets and medical necessity to continue IV Prevymis therapy

Medication being provided by(check applicable box below):

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

  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy Briova SpecialtyRx**

*****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: 7/10/2018