

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

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

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 Prevmis tablets and medical necessity to continue IV Prevmis therapy

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

****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 #: _____