

Prevymis™ Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below: <input type="checkbox"/> Prophylaxis of cytomegalovirus (CMV) infection and disease <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information: Is the patient a CMV-seropositive recipient [R+] of an allogeneic hematopoietic stem cell transplant (HSCT)? <input type="checkbox"/> Yes <input type="checkbox"/> No Will the medication be initiated between day 0 and day 28, before or after engraftment? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient receiving the medication beyond 100 days post-transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Quantity limit requests: What is the quantity requested per DAY? _____ Previous therapies failed and/or therapies currently used in combination with the requested medication (<i>List ALL medications tried or authorization process will be delayed</i>): _____ _____ Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature). <i>Please note: Chart documentation of the above is required to be submitted along with this fax</i> _____ _____					
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.*					
Prescriber Signature: _____			Date: _____		

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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