REALRx

PRIOR AUTHORIZATION REQUEST FORM
PREVYMIS™

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Prevymis™ (letermovir)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.			
Questions	**Yes**	**No**	**Comments/Notes**
1. Is the requested medication being purchased by the provider's office and to be billed under the medical benefit ('buy-and-bill')?	☐	☐	
2. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
PROPHYLAXIS OF CMV INFECTION AND DISEASE IN ALLOGENEIC HEMATOPIOETIC STEAM CELL TRANSPLANT RECEIPENTS			
3. Is the requesting provider an infectious disease specialist, hematologist, oncologist, or transplant specialist?	☐	☐	
4. Does documentation show the member is cytomegalovirus (CMV)-seropositive [R+]?	☐	☐	**Please provide documentation**
5. Is the member an allogeneic hematopoietic stem cell transplant recipient?	☐	☐	**Please provide documentation**
6. Is the therapy initiated between day 0 and day 28 post-transplant?	☐	☐	**Please provide documentation**
7. Does the member have severe (Child-Pugh C) hepatic impairment?	☐	☐	**Please provide documentation**
PROPHYLAXIS OF CMV INFECTION AND DISEASE IN KIDNEY TRANSPLANT RECIPIENTS AT HIGH RISK			
1. Is the requesting provider an infectious disease specialist, hematologist, oncologist, or transplant specialist?	☐	☐	

2. Does documentation show the donor is cytomegalovirus (CMV) seropositive [D+]?	☐	☐	**Please provide documentation**
3. Does documentation show the member (recipient) is CMV seronegative [R-]	☐	☐	**Please provide documentation**
4. Is the member a kidney transplant recipient?	☐	☐	**Please provide documentation**
5. Does the member have a contraindication to valganciclovir and ganciclovir?	☐	☐	**Please provide documentation**
6. Is the therapy initiated between day 0 and day 7 post-transplant?	☐	☐	**Please provide documentation**
7. Does the member have severe (Child-Pugh C) hepatic impairment?	☐	☐	**Please provide documentation**
INJECTABLE PREVYMIS™			
1. Is the member unable to swallow or has severe dysphagia preventing the use of solid oral medication?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy: PHARM-100
Origination Date: 08/05/2020
Reviewed/Revised Date: 09/13/2023
Next Review Date: 09/13/2024
Current Effective Date: 10/01/2023