

PRIOR AUTHORIZATION REQUEST FORM PREVYMIS™

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department.

• For Medical Pharmacy please fax requests to: 801-213-1547

• For **Retail Pharmacy** please fax requests to: 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 Pharmacy Customer Service for assistance at 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	
Prophylaxis of CMV infection and disease in allogeneic hen	natopoi	ietic sten	n cell transplant recipients	
 Is the requesting provider an infectious disease specialist, hematologist, oncologist, or transplant specialist? 				
 Does documentation show the member is cytomegalovirus (CMV)-seropositive [R+]? 			Please provide documentation	
3. Is the member an allogeneic hematopoietic stem cell transplant recipient?			Please provide documentation	
4. Is the therapy initiated between day 0 and day 28 post- transplant?			Please provide documentation	
5. 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				
 Is the requesting provider an infectious disease specialist, hematologist, oncologist, or transplant specialist? 				
 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	

		-	1			
5. Does the patient have valganciclovir and ganciclovir?			Please provide documentation			
6. Is the therapy initiated between day 0 and day 7 post-			Please provide documentation			
transplant?						
7. Does the member have severe (Child-Pugh C) hepatic			Please provide documentation			
impairment?						
INJECTABLE PREVYM	IIS™					
1. Is the member unable to swallow or has severe dysphagia			Please provide documentation			
preventing the use of solid oral medication?						
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:						

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

Policy: PHARM-HU-100 Origination Date: 01/01/2022 Reviewed/Revised Date: 09/13/2023 Next Review Date: 09/13/2024 Current Effective Date: 10/01/2023

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.