

HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM LIVTENCITY®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department 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: Livtencity® (maribavir)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
CYTOMEGALOVIRUS (CMV) WITH POST-TRANSPLANT CMV INFECTION/DISEASE			
1. Is the member 12 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member weigh at least 35 kg?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Is the requesting provider an infectious disease specialist, hematologist, oncologist, or transplant specialist?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Is the member a recipient of hematopoietic stem cell or solid organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Has the member tried and failed, or have a contraindication, intolerance, or resistance to all of the following medications: • Ganciclovir or valganciclovir, foscarnet, and cidofovir	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Is the member on any other CMV antivirals?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
7. Is the member pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	

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-CHIP-127
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024

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