REALRx

PRIOR AUTHORIZATION REQUEST FORM
LIVTENCITY®

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: ☐ Livtencity® (maribavir)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.			
Questions	**Yes**	**No**	**Comments/Notes**
1. 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.	☐	☐	
CYTOMEGALOVIRUS (CMV) WITH POST-TRANSPLANT CMV INFECTION/DISEASE			
1. Is the member 12 years of age or older?	☐	☐	
2. Does the member weigh at least 35 kg?	☐	☐	**Please provide documentation**
3. Is the requesting provider an infectious disease specialist, hematologist, oncologist, or transplant specialist?	☐	☐	
4. Is the member a recipient of hematopoietic stem cell or solid organ transplant?	☐	☐	**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	☐	☐	**Please provide documentation**
6. Is the member on any other CMV antivirals?	☐	☐	**Please provide documentation**
7. Is the member pregnant?	☐	☐	

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-127
Origination Date: 12/17/2021
Reviewed/Revised Date: 01/19/2022
Next Review Date: 01/19/2023
Current Effective Date: 02/01/2022