REALRx

Healthy U
Health Choice Utah

PRIOR AUTHORIZATION REQUEST FORM
PREVYMIS™

For authorization, please answer each question and fax this form PLUS chart notes back to the RealRx Medicaid 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 Pharmacy Customer Service for assistance.

- Healthy U Medicaid: 855-856-5694
- Health Choice Utah: 855-864-1404

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 hematopoietic stem cell transplant recipients			
1. Is the requesting provider an infectious disease specialist, hematologist, oncologist, or transplant specialist?	☐	☐	
2. 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**
6. If the request is for 200 days of therapy, is the member high-risk?	☐	☐	**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 patient have 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:			
PRESCRIBER CERTIFICATION			
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.			
Physician's Signature:			**Date:**

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Policy: PHARM-MM-100
Origination Date: 01/01/2022
Reviewed/Revised Date: 09/10/2025
Next Review Date: 09/10/2026
Current Effective Date: 10/01/2025

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