

Iowa Department of Human Services

Request for Prior Authorization Letermovir (Prevymis™)

Iowa Health Link Hawl

(PLEASE PRINT - ACCURACY IS IMPORTANT)

FAX Completed Form To 1 (877) 733-3195 IOWA Provider Services 1 (844) 236-1464

| | | | | , | | |
|---|---|--------------------------------------|--------------------------|-----------------------------|--|--|
| I/ | Medicaid Member ID # | Patient name | | DOB | | |
| Patient address | | | | | | |
| Р | rovider NPI | Prescriber name | | Phone | | |
| Prescriber address | | | | Fax | | |
| Р | harmacy name | Address | | Phone | | |
| Р | rescriber must complete all informa | ation above. It must be legible, cor | rect. and complete or fe | orm will be returned. | | |
| | harmacy NPI | Pharmacy fax | NDC | | | |
| | | | | | | |
| Prior authorization is required for oral letermovir. Requests for intravenous letermovir should be directed to the member's medical benefit. Payment will be considered under the following conditions: | | | | | | |
| 1) | 1) Medication is to be used for the prophylaxis of cytomegalovirus (CMV) infection and disease; and | | | | | |
| • | Patient or donor is CMV-seropositive R+ (attach documentation); and | | | | | |
| 3) | Patient has received an allogenic hematopoietic stem cell transplant (HSCT) within the last 28 days (provide date patient received HSCT); and | | | | | |
| 4) | Is prescribed by or in consultation with a hematologist, oncologist, infectious disease or transplant specialist; and | | | | | |
| 5) | Patient is 18 years of age or older; and | | | | | |
| 6) | Dose does not exceed: | | | | | |
| | a) 240mg once daily when co-b) 480 mg once daily; and | administered with cyclosporing | 9 | | | |
| 7) | Patient must not be taking the following medications: a) pimozide; or b) ergot alkaloids (e.g., ergotamine, dihydroergotamine); or c) rifampin; or | | | | | |
| | , | avastatin, simvastatin, or repag | linide when co-admir | nistered with cyclosporine; | | |
| 8) | 8) Patient does not have severe (Child-Pugh Class C) hepatic impairment (provide score); and | | | | | |
| 9) Therapy duration will not exceed 100 days post- transplantation. | | | | | | |
| | Prevymis™ | | | | | |
| | Strength | Dosage Instructions | Quantity | Days Supply | | |
| Di- | agnosis: | | | | | |
| יוט | agnosis | | | | | |
| ls | patient or donor CMV-seropo | esitive R+? | (attach documentation | n) No | | |
| Has patient received HSCT within the last 28 days? Yes; date No | | | | | | |
| Prescriber specialty: ☐ Hematologist ☐ Oncologist ☐ Infectious Disease Specialist ☐ Transplant Specialist ☐ Other (specify and provide consultation with one of the above specialists): | | | | | | |
| Consultation date: Physician name, phone & specialty: | | | | | | |
| | | | | | | |

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| Will letermovir be co-administered with cyclosporine? | |
|--|--------------------|
| Yes; dose does not exceed 240mg once daily | |
| ☐ No; dose does not exceed 480mg once daily | |
| Does patient have concurrent therapy with any of the following? Pimozide; or Ergot alkaloids (e.g., ergotamine, dihydroergotamine); or Rifampin; or Atorvastatin, lovastatin, pitavastatin, simvastatin, or repaglinide with | Yes No |
| Does patient have severe (Child-Pugh Class C) hepatic impairment (Yes No Score: | provide score)? |
| Is patient established on medication? | |
| Yes; provide therapy start date: | |
| □ No | |
| Attach lab results and other documentation as necessary. | |
| Prescriber signature (Must match prescriber listed above.) | Date of submission |

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

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