Iowa Department of Human Services

Request for Prior Authorization
Letermovir (Prevymis™)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy 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) **Medication is to be used for the prophylaxis of cytomegalovirus (CMV) infection and disease; and**
2) **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-administered with cyclosporine**
   b) **480 mg once daily; and**
7) **Patient must not be taking the following medications:**
   a) **pimozide; or**
   b) **ergot alkaloids (e.g., ergotamine, dihydroergotamine); or**
   c) **rifampin; or**
   d) **atorvastatin, lovastatin, pitavastatin, simvastatin, or repaglinide when co-administered with cyclosporine; and**
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**

Diagnosis: _____

Is patient or donor CMV-seropositive R+? ☐ Yes (attach documentation) ☐ 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: _____

Request for Prior Authorization
Letermovir (Prevymis™)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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? ☐ Yes ☐ No

- Pimozide; or
- Ergot alkaloids (e.g., ergotamine, dihydroergotamine); or
- Rifampin; or
- Atorvastatin, lovastatin, pitavastatin, simvastatin, or repaglinide with co-administered with cyclosporine

Does patient have severe (Child-Pugh Class C) hepatic impairment (provide score)?

☐ Yes ☐ No 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.*