pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ANTIVIRALS, CMV – LIVTENCITY (maribavir) & PREVYMIS (letermovir) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antivirals, CMV** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	
Directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):	Diagnosis code (*required*):	
Is the requested medication being prescribed by or in consultation with a hematologist/oncologist, infectious disease specialist, or transplant specialist?	☐Yes ☐No	*Submit documentation of consultation.*

Complete all sections that apply to the beneficiary and this request. *Check all that apply and submit documentation for each item.*

1. For Livtencity (maribavir):
   - ☐The beneficiary is/was taking ganciclovir or valganciclovir:
     - ☐Ganciclovir/valganciclovir will be/was discontinued before starting Livtencity (maribavir)
   - ☐Is being treated for post-transplant CMV infection/disease
   - ☐Is continuing treatment with Livtencity (maribavir) upon inpatient discharge
   - ☐Tried and failed or has a reason not to try at least one of the following:
     - ☐cidofovir ☐foscarnet ☐ganciclovir ☐valganciclovir
   - ☐Has culture and sensitivity results showing that only Livtencity (maribavir) will be effective
   - ☐Is receiving concomitant therapy with carbamazepine OR phenobarbital
     - ☐The dose of Livtencity (maribavir) was adjusted according to FDA-approved package labeling

2. For Prevymis (letermovir):
   - ☐The beneficiary received a hematopoietic stem cell transplant (HSCT)
   - ☐Is CMV-seropositive
   - ☐Is at high risk for CMV reactivation (eg, cord blood transplant, CMV-seropositive donor)
   - ☐Is NOT receiving concomitant therapy with a contraindicated drug/drug combination (eg, ergot alkaloids, pimozide, pitavastatin/simvastatin + cyclosporine)
   - ☐Is or will be receiving concomitant therapy with cyclosporine
     - ☐The dose of Prevymis (letermovir) was adjusted according to FDA-approved package labeling
   - ☐For primary prophylaxis of CMV infection/disease after allogeneic HSCT:
     - ☐Initiated or will initiation treatment with Prevymis (letermovir) between day 0 and day 28

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: