

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>.

<input type="checkbox"/> New request <input type="checkbox"/> 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:			Suite #:	City/state/zip:	
Beneficiary ID#:		DOB:	Phone:		Fax:

CLINICAL INFORMATION

Product requested: <input type="checkbox"/> Prevmis tablet <input type="checkbox"/> Prevmis injection <input type="checkbox"/> Prevmis: _____			Strength:		
Directions:			Quantity:		Refills:
Diagnosis (<i>submit documentation</i>):			Diagnosis code (<i>required</i>):		
Is Prevmis being prescribed by or in consultation with a hematologist/oncologist, infectious disease specialist, or transplant specialist?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of consultation.</i>	
Did the beneficiary have an allogeneic hematopoietic stem cell transplant?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation.</i>	
Will the beneficiary be starting Prevmis between day 0 and day 28 post-transplantation?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation.</i>	
Is the beneficiary being prescribed Prevmis for prophylaxis of CMV infection and disease?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation.</i>	
Is the beneficiary CMV-seropositive?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation.</i>	
Does the beneficiary have evidence of CMV replication as demonstrated by antigenemia or PCR?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation.</i>	
Is the beneficiary at high risk for CMV reactivation?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation.</i>	
Will the beneficiary be taking any of the following drugs/drug combinations while taking Prevmis? <i>Check all that apply.</i>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit beneficiary's medication list.</i>	
<input type="checkbox"/> pimozone (Orap)	<input type="checkbox"/> pitavastatin + cyclosporine				
<input type="checkbox"/> ergot alkaloids (e.g., ergotamine)	<input type="checkbox"/> simvastatin + cyclosporine				

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

Prescriber Signature:	Date:
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