IOWA Health and Human Services

Request for Prior Authorization
Letermovir (Prevymis™)

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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 (PA) 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. **Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions and use in specific populations; and**
2. **Medication is to be used for the prophylaxis of cytomegalovirus (CMV) infection and disease; and**
3. **Patient has received an allogenic hematopoietic stem cell transplant (HSCT); and**
   a. **Patient or donor is CMV-seropositive [R+] (attach documentation); and**
   b. **Treatment is initiated between day 0 and day 28 post-transplantation with IV and/or oral therapy (before or after engraftment); and**
   c. **Therapy duration will not exceed 100 days post-transplantation or up to 200 days if patient is at high risk for late CMV infection (attach documentation); or**
4. **Patient is a kidney transplant recipient; and**
   a. **Donor is CMV-seropositive/recipient is CMV seronegative [D+/R-] (attach documentation); and**
   b. **Treatment is initiated between day 0 and day 7 post-transplantation with IV and/or oral therapy (before or after engraftment); and**
   c. **Therapy will not exceed 200 days post-transplantation; and**
5. **Is prescribed by or in consultation with a hematologist, oncologist, infectious disease or transplant specialist; and**
6. **Date of transplant is provided; and**
7. **Patient's weight (in kg) is provided.**

☐ **Prevymis**

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

Diagnosis: _____

☐ **Allogenic hematopoietic stem cell transplant:**

Provide transplant date: _____

Is patient or donor CMV-seropositive [R+]? ☐ Yes (attach documentation) ☐ No

Is treatment being initiated between day 0 and 28 post-transplantation with IV and/or oral therapy? ☐ Yes ☐ No

Attach documentation for therapy beyond 100 days post-transplantation for high risk late CMV infection, if applicable.

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☐ **Kidney transplant:**

Provide transplant date: _____

Is donor CMV-seropositive/recipient CMV seronegative [D+/R-]? ☐ Yes (attach documentation) ☐ No

Is treatment being initiated between day 0 and 7 post-transplantation with IV and/or oral therapy? ☐ Yes ☐ 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: _____
_____

Provide patient's weight in kg: _____

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 Health and Human Services, that the member continues to be eligible for Medicaid.*