Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

ANTIVIRALS, CMV

I. Requirements for Prior Authorization of Antivirals, CMV

A. Prescriptions That Require Prior Authorization

Prescriptions for Antivirals, CMV that meet any of the following conditions must be prior authorized:

1. A non-preferred Antiviral, CMV. See the Preferred Drug List (PDL) for the list of preferred Antivirals, CMV at: https://papdl.com/preferred-drug-list.

2. A prescription for Prevymis (letermovir).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antiviral, CMV, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred Antiviral, CMV, has a history of therapeutic failure, intolerance, or contraindication of the preferred Antivirals, CMV approved for the beneficiary's diagnosis or indication; **AND**

2. For Prevymis (letermovir), **all** of the following:

   a. Is prescribed Prevymis (letermovir) for prophylaxis of cytomegalovirus (CMV) infection and disease,

   b. Is age-appropriate according to U.S. Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

   c. Is prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

   d. Is prescribed Prevymis (letermovir) by or in consultation with an appropriate specialist (ie, hematologist/oncologist, infectious disease specialist, or transplant specialist),

   e. Had all potential drug interactions addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug, or counseling of the beneficiary of the risks associated with the use of both medications when they interact),

   f. Does not have a history of a contraindication to Prevymis (letermovir),

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g. Has received an allogeneic hematopoietic stem cell transplant,

h. Is CMV-seropositive,

i. Is at high risk for CMV reactivation,

j. Does not have evidence of CMV replication as demonstrated by antigenemia or polymerase chain reaction (PCR),

k. Will initiate or has initiated treatment with Prevymis (letermovir) between day 0 and day 28 post-transplantation;

NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Dose and Duration of Therapy

Requests for prior authorization of Prevymis (letermovir) for prophylaxis of CMV infection and disease following allogeneic hematopoietic stem cell transplant will be approved for up to 100 days following the date of transplant.

D. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Antiviral, CMV. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

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PREVYMIS (letermovir) PRIOR AUTHORIZATION FORM

☐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:		Suite #: / City/state/zip:
Beneficiary ID#:	DOB:	Phone: / Fax:
Medication will be billed via: ☐ Pharmacy ☐ Medical (Jcode:)		Place of Service: ☐ Hospital ☐ Provider's Office ☐ Home ☐ Other

CLINICAL INFORMATION

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

PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

Prescriber Signature:	**Date:**

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