AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Prevymis® (letermovir) **tablets (Pharmacy)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Quantity Limit: 1 tablet per day (all strengths)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **Diagnosis: Cytomegalovirus, prophylaxis in hematopoietic cell transplant recipients**

Initiate therapy between Day 0 and Day 28 post-HSCT (before or after engraftment) and continue through Day 100 post-HSCT. In patients at risk for late CMV infection and disease, Prevymis® may be continued through Day 200 post-HSCT.

Recommended Dosage:

- **Adult and Pediatric Patients 12 Years of Age and Older and Weighing at least 30 kg:** 480 mg administered orally once daily

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Recommended Dosage:

- **Pediatric Patients 6 Months to Less than 12 Years of Age or 12 Years of Age and Older and Weighing Less than 30 kg:**

Body Weight	Daily Oral Dose	Tablets	Oral Pellets*
15 kg to less than 30 kg	240 mg	One 240 mg tablet	Two 120 mg packets
7.5 kg to less than 15 kg	120 mg	Not Recommended	One 120 mg packet
6 kg to less than 7.5 kg	80 mg	Not Recommended	Four 20 mg packets

*Commercial availability of oral pellets is still pending

Length of Authorization: 200 days of therapy

- ❑ Member is 6 months of age or older and weighs at least 6 kg
- ❑ Member will be receiving Prevymis® for the prophylaxis of cytomegalovirus (CMV) disease
- ❑ Member is a CMV-seropositive recipient [R+] of an allogeneic hematopoietic stem cell transplant (HSCT)
- ❑ Medication will be initiated between day 0 and day 28, before or after engraftment
  - Enter date transplant was performed: _____
- ❑ Member is **NOT** receiving the requested medication beyond 200 days post-transplantation

❑ Diagnosis: Cytomegalovirus, prophylaxis in kidney transplant recipients

Initiate therapy between Day 0 and Day 7 post-transplant and continue through Day 200 post-transplant.

Recommended Dosage:

- **Adult and Pediatric Patients 12 Years of Age and Older and Weighing at least 40 kg:** 480 mg administered orally once daily

Length of Authorization: 200 days of therapy

- ❑ Member is 12 years of age or older and weighs at least 40 kg
- ❑ Member will be receiving a kidney transplant
- ❑ Member will be receiving Prevymis® for the prophylaxis of cytomegalovirus (CMV) disease
- ❑ Member is at high-risk for CMV disease [documentation recording kidney donor is CMV-seropositive, and the recipient (member) is CMV-seronegative (D+/R-)]
- ❑ Medication will be initiated between day 0 and day 7, before or after engraftment
  - Enter date transplant was performed: _____
- ❑ Member is **NOT** receiving the medication beyond 200 days post-transplantation

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Medication being provided by Specialty Pharmacy – Proprium Rx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by the Pharmacy and Therapeutics Committee:** ~~2/15/2018; 9/21/2023;~~ **11/21/2024**
REVISED/UPDATED/REFORMATTED: ~~6/21/2018; 1/9/2020; 10/17/2023,~~ **12/17/2024**