

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

Prior authorization guidelines for **Antivirals, CMV** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at

<https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger>

<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:		City/state/zip:		
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Strength:	
Directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):	Diagnosis code (<i>required</i>):	
Is the requested medication 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>	

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

<p>1. For Livtency (maribavir):</p> <p><input type="checkbox"/> The beneficiary is/was taking ganciclovir or valganciclovir: <input type="checkbox"/> Ganciclovir/valganciclovir will be/was discontinued before starting Livtency (maribavir)</p> <p><input type="checkbox"/> Is being treated for post-transplant CMV infection/disease</p> <p><input type="checkbox"/> Is continuing treatment with Livtency (maribavir) upon inpatient discharge</p> <p><input type="checkbox"/> Tried and failed or has a reason not to try at least one of the following: <input type="checkbox"/> cidofovir <input type="checkbox"/> foscarnet <input type="checkbox"/> ganciclovir <input type="checkbox"/> valganciclovir</p> <p><input type="checkbox"/> Has culture and sensitivity results showing that only Livtency (maribavir) will be effective</p> <p><input type="checkbox"/> Is receiving concomitant therapy with carbamazepine OR phenobarbital <input type="checkbox"/> The dose of Livtency (maribavir) was adjusted according to FDA-approved package labeling</p>
<p>2. For Prevymis (letermovir):</p> <p><input type="checkbox"/> The beneficiary received a hematopoietic stem cell transplant (HSCT)</p> <p><input type="checkbox"/> Is CMV-seropositive</p> <p><input type="checkbox"/> Is at high risk for CMV reactivation (eg, cord blood transplant, CMV-seropositive donor)</p> <p><input type="checkbox"/> Is NOT receiving concomitant therapy with a contraindicated drug/drug combination (eg, ergot alkaloids, pimozide, pitavastatin/simvastatin + cyclosporine)</p> <p><input type="checkbox"/> Is or will be receiving concomitant therapy with cyclosporine <input type="checkbox"/> The dose of Prevymis (letermovir) was adjusted according to FDA-approved package labeling</p> <p><input type="checkbox"/> For primary prophylaxis of CMV infection/disease after allogeneic HSCT: <input type="checkbox"/> Initiated or will initiation treatment with Prevymis (letermovir) between day 0 and day 28</p>

Please submit to PromptPA <https://ghp.promptpa.com> OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	Date:
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