GHP Family Pharmacy Customer Service
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PREVYMIS (letermovir) PRIOR AUTHORIZATION FORM *(form effective 01/01/2020)*

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

☐ New request ☐ Renewal request	Total # pages: _______	Prescriber name:	
Name of office contact:		Specialty:	
Phone number of office contact:		NPI:	State license #:
Facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested: ☐ Prevymis tablet ☐ Prevymis injection ☐ Prevymis:___________		Strength:
Directions:	Quantity:	Refills:
Diagnosis (*Submit documentation*):	Dx code (*required*):	

Question	Response
Is the beneficiary being prescribed Prevymis for prophylaxis of cytomegalovirus (CMV) infection and disease?	☐ Yes ☐ No *Submit documentation*
Is Prevymis being prescribed by or in consultation with an appropriate specialist (i.e. hematologist/oncologist, infectious disease specialist, or transplant specialist)?	☐ Yes ☐ No *Submit documentation of consultation*
Have all potential drug interactions been addressed, as evidenced by one of the following: ☐ Discontinuation of the interacting drug ☐ Dose reduction of the interacting drug ☐ Counseling of the beneficiary of the risks associated with the use of both medications when they interact	☐ Yes ☐ No ☐ Not Applicable
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*
Did the beneficiary have an allogeneic hematopoietic stem cell transplant?	☐ Yes ☐ No *Submit documentation*
Did the beneficiary have a mental health evaluation?	☐ 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 polymerase chain reaction (PCR)?	☐ Yes ☐ No *Submit documentation*
Will the beneficiary be starting Prevymis between day 0 and day 28 post-transplantation?	☐ Yes ☐ No *Submit documentation*
Date of transplant:	

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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