

ANTIVIRALS, CMV PRIOR AUTHORIZATION FORM (form effective 1/8/2024)

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:	Dosage form:	
Directions:		Quantity:	Refills:
Diagnosis (<u>submit documentation</u>):		Diagnosis code (<u>required</u>):	
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 <u>Livtency (maribavir)</u>:</p> <p><input type="checkbox"/> The beneficiary is/was taking ganciclovir or valganciclovir AND:</p> <p> <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 AND:</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:</p> <p> <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 AND:</p> <p> <input type="checkbox"/> The dose of Livtency (maribavir) was adjusted according to FDA-approved package labeling</p>
<p>2. For <u>Prevymis (letermovir)</u>:</p> <p><input type="checkbox"/> Is using Prevymis (letermovir) for post-transplant CMV prophylaxis AND:</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 with cyclosporine, simvastatin with cyclosporine)</p>

- ☐ Is or will be receiving concomitant therapy with cyclosporine AND:
 - ☐ The dose of Prevymis (letermovir) was adjusted according to FDA-approved package labeling
- ☐ Initiated or will initiate treatment with Prevymis (letermovir) in the post-transplant period in accordance with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- ☐ Is continuing treatment with Prevymis (letermovir) upon inpatient discharge

3. For all other NON-PREFERRED Antivirals, CMV:

- ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Antivirals, CMV approved or medically accepted for the beneficiary's diagnosis or condition (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.)
- ☐ Has culture and sensitivity results showing BOTH of the following:
 - ☐ The beneficiary's infection is NOT susceptible to the preferred Antivirals, CMV
 - ☐ The beneficiary's infection IS susceptible to the requested non-preferred Antivirals, CMV

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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