HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
PREVYMIS™

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

- For **Medical Pharmacy** please fax requests to 801-213-1547
- For **Retail Pharmacy** requests please fax requests to: 888-509-8142

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC: 855-885-7695, Advantage U Part B: 888-605-0858

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Prevymis™ (letermovir)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older?	☐	☐	
2. Is the requesting provider an infectious disease specialist, hematologist, oncologist, or transplant specialist?	☐	☐	
3. Does documentation show the member is cytomegalovirus (CMV)-seropositive [R+]?	☐	☐	**Please provide documentation**
4. Is the member an allogeneic hematopoietic stem cell transplant recipient?	☐	☐	**Please provide documentation**
5. Is the therapy initiated between day 0 and day 28 post-transplant?	☐	☐	**Please provide documentation**
INJECTABLE PREVYMIS™			
6. Is the member unable to swallow or has severe dysphagia preventing the use of solid oral medication?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

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Policy: PHARM- 100
Origination Date: 08/05/2020
Reviewed/Revised Date: 08/19/2020
Next Review Date: 08/19/2021
Current Effective Date: 09/01/2020