Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Antivirals - CMV

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this a request for Prevymis (letermovir)?

☐ Yes ☐ No

Q2. Is Prevymis (letermovir) being prescribed for the prophylaxis of cytomegalovirus (CMV) infection and disease?

☐ Yes ☐ No

Q3. Is the patient of an appropriate age for the requested drug according to Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Is the patient prescribed a dose and duration of therapy that is consistent with Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q5. Is Prevymis (letermovir) being prescribed by or in consultation with an appropriate specialist (i.e., hematologist/oncologist, infectious disease specialist, or transplant specialist)?

☐ Yes ☐ No

Q6. Have all potential drug interactions been addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug, or counseling the patient of the risks associated with the use of both medications when they interact)?

☐ Yes ☐ No

Q7. Does the patient have a history of a contraindication to Prevymis (letermovir)?

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q8. Has the patient received an allogeneic hematopoietic stem cell transplant?	
☐ Yes	☐ No
Q9. Is the patient cytomegalovirus (CMV) seropositive?	
☐ Yes	☐ No
Q10. Is the patient at a high risk of cytomegalovirus (CMV) reactivation?	
☐ Yes	☐ No
Q11. Does the patient have evidence of cytomegalovirus (CMV) replication, as demonstrated by antigenemia or polymerase chain reaction (PCR)?	
☐ Yes	☐ No
Q12. Will the patient initiate treatment with Prevymis (letermovir) or has the patient initiated treatment with Prevymis (letermovir) between day 0 and day 28 post-transplantation?	
☐ Yes	☐ No
Q13. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred cytomegalovirus (CMV) antiviral drugs for the patient's diagnosis or indication (e.g., Prevymis, Valcyte oral solution, valganciclovir tablet)?	
☐ Yes	☐ No
Q14. Additional Information:	

Prescriber Signature _____ Date _____

Updated for 2020