



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Antivirals - Cytomegalovirus (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.

Form with fields: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, Directions, Diagnosis Code, Diagnosis, Strength, Refills, Specialty Pharmacy.

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 Prevmis (letermovir)?

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

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 checkbox

No checkbox

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 checkbox

No checkbox

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

Yes checkbox

No checkbox

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 checkbox

No checkbox

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



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Patient Name: Prescriber Name:

Form with questions Q8-Q13 and Q14. Q8: Has the patient received an allogeneic hematopoietic stem cell transplant? Q9: Is the patient cytomegalovirus (CMV) seropositive? Q10: Is the patient at a high risk of cytomegalovirus (CMV) reactivation? Q11: Does the patient have evidence of cytomegalovirus (CMV) replication... Q12: Will the patient initiate treatment with Prevmis... Q13: Does the patient have a documented history of therapeutic failure... Q14: Additional Information:

Prescriber Signature

Date

Updated for 2022