Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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.

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 there notes showing what Prevymis (letermovir) is being used to treat?

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

☐ Yes ☐ No

Q5. Has the patient received a stem cell transplant?

☐ Yes ☐ No

Q6. Is the patient cytomegalovirus (CMV) seropositive?

☐ Yes ☐ No

Q7. Is the patient at a high risk of cytomegalovirus (CMV) reactivation?

☐ Yes ☐ No

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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.

Patient Name:	Prescriber Name:

Q8. 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

Q9. Does the patient have evidence of cytomegalovirus (CMV) replication, as demonstrated by antigenemia or polymerase chain reaction (PCR)?

☐ Yes ☐ No

Q10. Is this a request for maribavir?

☐ Yes ☐ No

Q11. Is maribavir being prescribed by or in consultation with an appropriate specialist (i.e., hematologist/oncologist, infectious disease specialist, or transplant specialist)?

☐ Yes ☐ No

Q12. Is there notes showing what maribavir is being used to treat?

☐ Yes ☐ No

Q13. Is prescribed maribavir for continuation of treatment upon inpatient discharge?

☐ Yes ☐ No

Q14. Does the patient history of therapeutic failure of or a contraindication or an intolerance to at least one of the following (Ganciclovir, Valganciclovir, Cidofovir, Foscarnet)?

☐ Yes ☐ No

Q15. Does the patient have culture and sensitivity results documenting that only maribavir will be effective?

☐ Yes ☐ No

Q16. 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

Q17. Is the beneficiary's infection not susceptible to the preferred Antivirals, CMV?

☐ Yes ☐ No

Q18. Is the beneficiary's infection susceptible to the requested non-preferred Antiviral, CMV?

☐ Yes ☐ No

Q19. Additional Information:

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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.

Patient Name:	Prescriber Name:

Prescriber Signature _____ Date _____

Updated for 2023