pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

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 the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐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 (*submit documentation*):		Diagnosis code (*required*):	
Is the requested medication being prescribed by or in consultation with a hematologist/oncologist, infectious disease specialist, or transplant specialist?		☐Yes ☐No	*Submit documentation of consultation.*

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

1. For Livtencity (maribavir):
   - ☐The beneficiary is/was taking ganciclovir or valganciclovir AND:
     - ☐Ganciclovir/valganciclovir will be/was discontinued before starting Livtencity (maribavir)
   - ☐Is being treated for post-transplant CMV infection/disease AND:
     - ☐Is continuing treatment with Livtencity (maribavir) upon inpatient discharge
     - ☐Tried and failed or has a reason not to try at least one of the following:
       - ☐cidofovir ☐foscarnet ☐ganciclovir ☐valganciclovir
     - ☐Has culture and sensitivity results showing that only Livtencity (maribavir) will be effective
   - ☐Is receiving concomitant therapy with carbamazepine OR phenobarbital AND:
     - ☐The dose of Livtencity (maribavir) was adjusted according to FDA-approved package labeling

2. For Prevymis (letermovir):
   - ☐Is using Prevymis (letermovir) for post-transplant CMV prophylaxis AND:
     - ☐Is CMV-seropositive
     - ☐Is at high risk for CMV reactivation (eg, cord blood transplant, CMV-seropositive donor)
   - ☐Is NOT receiving concomitant therapy with a contraindicated drug/drug combination (eg, ergot alkaloids, pimozide, pitavastatin with cyclosporine, simvastatin with cyclosporine)

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- ☐ 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 FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: