GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

# 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 Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

| | | | |
|---|---|---|---|
| ☐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: |
| Beneficiary address: | | Beneficiary phone number: | |

## 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

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**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)

☐ 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 submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.**

| **Prescriber Signature:** | **Date**: |
|---|---|
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