

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Prevymis - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at
1-410-424-4607. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the
Prior Authorization process.
When conditions are met, we will authorize the coverage of Prevymis - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Prevymis (Ietermovir)

Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the patient 18 years of age or older? Y N

[If no, then no further questions.]

2. Is there documentation that Prevymis will be used for prophylaxis of cytomegalovirus (CMV) infection and disease in an adult CMV-seropositive recipient of an allogenic hematopoietic stem cell transplant (HSCT)? Y N

[Note: Documentation must be submitted.]

[If no, then no further questions.]

3. Is there documentation showing the date of Hematopoietic Stem Cell Transplantation (HSCT)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
4. Is therapy being initiated between Day 0 and Day 28 following Hematopoietic Stem Cell Transplantation (HSCT)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	
5. Does the patient have any of the following: A) Concomitant use with pimozide or ergot alkaloids, B) Co-administered with cyclosporine in conjunction with either pitavastatin or simvastatin, C) Treatment exceeding Day 100 post-transplantation?	<input type="checkbox"/> Y <input type="checkbox"/> N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date