Priority Partners MCO
7231 Parkway Drive, Suite 100
Hanover, MD 21076

JOHNS HOPKINS MEDICINE

JOHNS HOPKINS HEALTHCARE

Prior Authorization

JOHNS HOPKINS HEALTHCARE (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 Healthcare at **1-410-424-4607**.
Please contact Johns Hopkins Healthcare 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 (letermovir)

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)?	Y 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)?	Y 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?	Y 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