

CAREFIRST
Prevymis Limit-Post Limit

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Prevymis Limit-Post Limit.

Patient Information

Patient Name:	<input type="text"/>
Patient Phone:	<input type="text"/>
Patient ID:	<input type="text"/>
Patient Group:	<input type="text"/>
Patient DOB:	<input type="text"/>

Physician Information

Physician Name	<input type="text"/>
Physician Phone:	<input type="text"/>
Physician Fax:	<input type="text"/>
Physician Addr.:	<input type="text"/>
City, St, Zip:	<input type="text"/>

Drug Name (select from list of drugs shown)

Prevymis Oral Pellets (letermovir) Prevymis 240mg Tablets (letermovir) Prevymis 480mg Tablets (letermovir)

Quantity:	_____	Frequency:	_____	Strength:	_____
Route of Administration:	_____				
Expected Length of Therapy:	_____				
Diagnosis:	_____	ICD Code:	_____		
Comments:	_____				

Please check the appropriate answer for each applicable question.

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|----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|--------------------------|---|--------------------------|
| 1. | Is the requested drug being prescribed for the prophylaxis of cytomegalovirus (CMV) infection and disease in adult or pediatric patients 6 months of age and older and weighing at least 6 kg who are CMV-seropositive recipients [R+] of an allogeneic hematopoietic stem cell transplant (HSCT)? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 2. | Is the requested drug being prescribed for the prophylaxis of CMV disease in adult or pediatric patients 12 years of age and older and weighing at least 40 kg who are kidney transplant recipients at high risk (Donor CMV seropositive/Recipient CMV seronegative [D+/R-])? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 3. | Is there a valid medical reason why the patient requires treatment beyond the recommended duration post transplantation? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |

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

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.