

nhysician portion and submit this completed form

BlueShield. LIVTENCITY Federal Employee Program. PRIOR APPROVAL REQUEST

Send completed form to: Service Benefit Plan Prior Approval P.O. Box 52080 MC 139 Phoenix, AZ 85072-2080 Attn. Clinical Services Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the

Patient Information (required)			Provider Information (required)			
Date:	Provider Name:					
Patient Name:			Specialty:	ecialty: NPI:		
Date of Birth:	e of Birth: Sex: DMale DFemale		Office Phone:		Office Fax:	
Street Address:			Office Street Addre	SS:	•	
City:	State:	Zip:	City:	Stat	e:	Zip:
Patient ID: R	Physician Signature:					
PHYSICIAN COMPLETES						

Livtencity (maribavir)

**Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit

NOTE: Form must be completed in its entirety for processing

Is this request for brand or generic? Brand Generic

How many tablets will the patient need for a 56 day supply (8 weeks)? ______ tablet(s) per 56 days (8 weeks)

- 1. What is the patient's diagnosis?
 - Cytomegalovirus (CMV) infection/disease
 - □ Other diagnosis (*please specify*):___

2. Is the patient post-hematopoietic stem cell transplant (HSCT) **OR** post-solid organ transplant (SOT)? **D**Yes **D**No

3. What is the patient's weight? _____ kg OR _____ lbs

4. Will the patient receive concurrent therapy with ganciclovir or valganciclovir? \Box Yes \Box No

5. Does the prescriber agree to monitor CMV DNA levels and check for resistance if patient does not respond to treatment? \Box Yes \Box No

6. Is this INITIATION or CONTINUATION of therapy? Please select answer below:

INITIATION of therapy, please answer the following questions:

- a. Is the patient refractory to treatment with ONE of the following: ganciclovir, valganciclovir, cidofovir, or foscarnet? \Box Yes \Box No
- b. Does the patient have an intolerance or contraindication, such as bone marrow suppression, to ganciclovir or valganciclovir? □Yes □No*

**If NO*, does the patient have an intolerance or contraindication, such as having or being at high risk for nephrotoxicity, to cidovovir or foscarnet? \Box Yes \Box No

CONTINUATION (PA renewal) of therapy, please answer the following question:

a. Has the patient developed a resistance to Livtencity (maribavir)? **D**Yes **D**No



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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 minutes FASTEST AND EASIEST	Now you can get responses to drug Prior Authorization requests securely online. Online submissions may receive instant responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to Caremark.com/ePA.
Phone (4-5 minutes for response)	The FEP Clinical Call Center can be reached at (877)-727-3784 between the hours of 7AM- 9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 days for response)	Fax the attached form to (877)-378-4727. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. <u>Please only fax the completed form once as</u> <u>duplicate submissions may delay processing</u> <u>times.</u>

faster	Introducing ePA! Online Prior
easier	Authorizations in minutes through Caremark.com/ePA . Sign up today!
better	
	CVS/caremark ⁻ 🥰

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and largere to provide any such information to the insurer. Livtencity – FEP MD Fax Form Revised 4/29/2022