BlueCross BlueShield Federal Employee Program

PREVYMIS
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 physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Prevymis (letermovir)

NOTE: Form must be completed in its **entirety** for processing

Please select strength:

❑ **240 mg tablet**	❑ **20 mg oral packets**	❑ **240 mg (12 mL vial)**
❑ **480 mg tablet**	❑ **120 mg oral packets**	❑ **480 mg (24 mL vial)**

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

Is this request for brand or generic? ❑Brand ❑Generic

How many tablets/oral packets/vials will the patient need for a 200 day supply? _____ tablet(s)/oral packet(s)/vial(s) per 200 days

1. Is Prevymis being used for the prevention of cytomegalovirus (CMV) infection and disease? ❑Yes* ❑No
   If YES, is the patient post hematopoietic stem cell transplant (HSCT) or post kidney transplant? ***Please select answer below:***
   - ❑**YES - Post HSCT**: Please answer the following questions:
     a. Did the patient receive the transplant within the last 28 days? ❑Yes ❑No
     b. Is the patient a CMV seropositive recipient [R+]? ❑Yes ❑No
   - ❑**YES - Post kidney transplant**: Please answer the following questions:
     a. Did the patient receive the transplant within the last 7 days? ❑Yes ❑No
     b. Is the donor CMV seropositive? ❑Yes* ❑No
        If YES, is the patient a CMV seronegative recipient? ❑Yes ❑No
   - ❑**NO**

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

3. Does the patient have severe hepatic impairment (Child-Pugh Class C)? ❑Yes ❑No

4. Does the prescriber agree to monitor for CMV reactivation? ❑Yes ❑No

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 I agree to provide any such information to the insurer. Prevymis – FEP CSU_MD Fax Form Revised 2/28/2025