

### Clinical Pharmacy Program Guidelines for Prevmis

Program	Prior Authorization
Medication	Prevmis™ (letermovir)
Markets in Scope	Arizona, California, Hawaii, Maryland, Nevada, New Jersey, New York, New York EPP, Pennsylvania-CHIP, Rhode Island, South Carolina
Issue Date	6/2018
Pharmacy and Therapeutics Approval Date	6/2020
Effective Date	8/2020

**1. Background:**

Prevmis is a CMV DNA terminase complex inhibitor indicated for prophylaxis of cytomegalovirus (CMV) infection and disease in adult CMV-seropositive recipients [R+] of an allogeneic hematopoietic stem cell transplant (HSCT).

**2. Coverage Criteria:**

<p><b>A. <u>Authorization</u></b></p> <ol style="list-style-type: none"> <li>1. Patient is a recipient of an allogeneic hematopoietic stem cell transplant</li> </ol> <p style="text-align: center;"><b>-AND-</b></p> <ol style="list-style-type: none"> <li>2. Patient is CMV-seropositive</li> </ol> <p style="text-align: center;"><b>-AND-</b></p> <ol style="list-style-type: none"> <li>3. Provider attests that Prevmis will be initiated between Day 0 and Day 28 post-transplantation (before or after engraftment) and is being prescribed as prophylaxis and not treatment of CMV infection</li> </ol> <p><b>Authorization will be issued for 6 months.</b></p>
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**3. Additional Clinical Rules:**

- **Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.**
- **Supply limits, Step Therapy, and/or Medical Necessity may be in place.**

**4. References:**

1. Prevmis Prescribing Information. Merck & Co., Inc. March 2020.

Program	Program type –Prior Authorization
<b>Change Control</b>	
Date	Change
6/2018	New Program
6/2019	Annual review with no change to coverage criteria. Updated reference.
6/2020	Annual review. Updated reference. Added Additional Clinical Rules section.