



UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2021 P 1246-4
Program	Prior Authorization/Notification
Medication	Prevymis™ (letermovir)
P&T Approval Date	6/2018, 6/2019, 6/2020, 6/2021
Effective Date	9/1/2021; Oxford only: 9/1/2021

1. Background:

Prevymis (letermovir) 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:

A. Cytomegalovirus Prophylaxis

1. Initial Therapy

a. **Prevymis** will be approved based on **all** of the following criteria

(1) Patient is a recipient of an allogeneic hematopoietic stem cell transplant

-AND-

(2) Patient is CMV-seropositive

-AND-

(3) Provider attests that Prevymis 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

Authorization will be issued for 6 months by OptumRx.

2. Reauthorization

All requests for reauthorization will be **denied by OptumRx**. All requests for continuation of therapy must be submitted through the appeals process to UnitedHealthcare Pharmacy appeals for consideration.

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. Preymis Prescribing Information. Merck & Co., Inc. February 2021.

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Change Control	
6/2018	New program
6/2019	Annual review with no change to coverage criteria. Updated reference.
6/2020	Annual review with no changes to coverage criteria.
6/2021	Annual review with no changes to coverage criteria.