maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Prevymis

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	What is the diagnosis or indication? [] Cytomegalovirus (CMV) prophylaxis (If checked, go to 2) [] Other (If checked, no further questions)		
2	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
3	Is the requested medication being prescribed by or in consultation with an oncology, hematology, infectious disease, or transplant specialist? [If no, no further questions.]	Yes	No

If you have any questions, call:
1-888-258-8250

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4	Has documentation been submitted to confirm that the patient is a cytomegalovirus (CMV) recipient of one of the following? ACTION REQUIRED: Submit supporting documentation. [] Cytomegalovirus (CMV) seropositive recipient; Allogenic hematopoietic stem cell transplant (HSCT) (If checked, go to 5) [] Cytomegalovirus (CMV) seronegative recipient; Adult kidney transplant recipient at high risk (If checked, go to 5) [] Other (If checked, no further questions)		
5	Is the patient being treated for an active cytomegalovirus (CMV) infection? [If yes, no further questions.]	Yes	No
6	Is the provider initiating the requested medication between day 0 and day 28 post transplantation (before or after engraftment)? [If no, no further questions.]	Yes	No
7	Is the requested medication being prescribed as prophylaxis therapy? [If no, no further questions.]	Yes	No
8	Has the patient tried, have a contraindication to, or intolerance to valganciclovir or valacyclovir? [If no, no further questions.]	Yes	No
9	Does the patient have severe (Child-Pugh C) hepatic impairment? [If yes, no further questions.]	Yes	No
10	Is the requested medication being co-administered with cyclosporine? [If no, no further questions.]	Yes	No
11	Is the requested medication being used in conjunction with pimozide, ergot alkaloids, pitavastatin and simvastatin when co-administered with cyclosporine? [If yes, no further questions.]	Yes	No
12	Can the prescriber attest that the dosage of the requested medication will not exceed 240 mg daily?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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