# 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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is this request for initial therapy or for a continuation of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

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

Version 02.2026

# PRIOR AUTHORIZATION REQUEST

| | | | |
|---|---|---|---|
| 3 | Has the patient been receiving medication samples of the requested medication?<br>[If yes, skip to question 7.] | Yes | No |
| 4 | Does the patient have a previously approved prior authorization (PA) on file with the current plan?<br>[Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.]<br>[If no, skip to question 7.] | Yes | No |
| 5 | Has the patient been established on therapy for at least 3 months?<br>[If no, skip to question 7.] | Yes | No |
| 6 | Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation.<br>[No further questions.] | Yes | No |
| 7 | What is the diagnosis or indication?<br>[] Cytomegalovirus (CMV) prophylaxis (If checked, go to 8)<br><br>[] Other (If checked, no further questions) | | |
| 8 | Is the requested medication being prescribed by or in consultation with an oncology, hematology, infectious disease, or transplant specialist?<br>[If no, no further questions.] | Yes | No |
| 9 | Has documentation been submitted to confirm that the patient is a cytomegalovirus (CMV) recipient of one of the following? ACTION REQUIRED: Submit supporting documentation.<br>[] Cytomegalovirus (CMV) seropositive recipient; Allogenic hematopoietic stem cell transplant (HSCT) (If checked, go to 10)<br><br>[] Cytomegalovirus (CMV) seronegative recipient; Adult kidney transplant recipient at high risk (If checked, go to 11)<br><br>[] Other (If checked, no further questions) | | |
| 10 | Is the patient 6 months of age or older and weighs at least 6 kg?<br>[If yes, skip to question 12.]<br>[If no, no further questions.] | Yes | No |
| 11 | Is the patient 12 years of age or older and weighs at least 40 kg?<br>[If no, no further questions.] | Yes | No |
| 12 | Is the patient being treated for an active cytomegalovirus (CMV) infection?<br>[If yes, no further questions.] | Yes | No |

maryland physicians care
Medicaid with a Heart

# PRIOR AUTHORIZATION REQUEST

| | | | |
|---|---|---|---|
| 13 | Is the provider initiating the requested medication between day 0 and day 28 post transplantation (before or after engraftment)?<br>[If no, no further questions.] | Yes | No |
| 14 | Is the requested medication being prescribed as prophylaxis therapy?<br>[If no, no further questions.] | Yes | No |
| 15 | Has the patient tried, have a contraindication to, or intolerance to valganciclovir or valacyclovir?<br>[If no, no further questions.] | Yes | No |
| 16 | Does the patient have severe (Child-Pugh C) hepatic impairment?<br>[If yes, no further questions.] | Yes | No |
| 17 | Is the requested medication being co-administered with cyclosporine?<br>[If no, no further questions.] | Yes | No |
| 18 | Is the requested medication being used in conjunction with pimozide, ergot alkaloids, pitavastatin and simvastatin when co-administered with cyclosporine?<br>[If yes, no further questions.] | Yes | No |
| 19 | 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:***

## 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.

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