



## PRIOR AUTHORIZATION REQUEST

### LIVTENCITY

**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 the request for an INITIAL or a CONTINUATION of therapy?

Initial (If checked, go to 6)

Continuation (If checked, go to 2)

2      Is the patient currently receiving the requested medication? Yes      No

[If no, skip to question 6.]

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

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|    |  |     |    |
|----|--|-----|----|
| 3  | Has the patient been receiving medication samples of the requested medication?<br>[If yes, skip to question 6.]  | 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 6.]   | Yes | No |
| 5  | Has the patient been taking the requested medication for AT LEAST 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation.<br>[Note: Cytomegalovirus (CMV) polymerase chain DNA laboratory results within the past 4 weeks demonstrating improvement in CMV levels.]<br>[No further questions.] | Yes | No |
| 6  | What is the diagnosis or indication?<br><br><input type="checkbox"/> Cytomegalovirus infection (If checked, go to 7)<br><br><input type="checkbox"/> Other (If checked, no further questions)  |     |    |
| 7  | Is the patient greater than or equal to 12 years of age?<br>[If no, no further questions.]   | Yes | No |
| 8  | Is the patient's weight greater than or equal to 35 kg?<br>[If no, no further questions.]  | Yes | No |
| 9  | Is the patient post-transplant?<br>[Note: This includes patients who are post-hematopoietic stem cell transplant (HSCT) or post-solid organ transplant (SOT).]<br>[If no, no further questions.]   | Yes | No |
| 10 | Is the requested medication being prescribed in conjunction with ganciclovir or valganciclovir?<br>[If yes, no further questions.]   | Yes | No |
| 11 | Does the patient have a diagnosis of cytomegalovirus (CMV) disease that involves the central nervous system, including CMV retinitis?<br>[If yes, no further questions.]   | Yes | No |
| 12 | Is the requested medication being used for the for the prevention of cytomegalovirus (CMV) infection?<br>[If yes, no further questions.]   | Yes | No |
| 13 | If the patient is not responding to treatment, does the provider agree to monitor  | Yes | No |

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cytomegalovirus (CMV) DNA levels and check for resistance?  
 [If no, no further questions.]

- |    |   |     |    |
|----|---|-----|----|
| 14 | Has documentation been submitted to confirm that the patient is refractory to treatment with AT LEAST 1 of the following: cidofovir, foscarnet, ganciclovir, or valganciclovir, unless contraindicated or intolerant? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.]   | Yes | No |
| 15 | Has documentation been submitted to confirm that the patient has failed to achieve GREATER THAN 1 log 10 decrease in cytomegalovirus (CMV) DNA level in whole blood or plasma after MORE THAN 14 days of treatment with AT LEAST 1 medication such as cidofovir, foscarnet, ganciclovir, or valganciclovir? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 16 | Is the requested medication being prescribed by or in consultation with a hematologist, infectious diseases specialist, oncologist, or a transplant physician?<br>[If no, no further questions.]  | Yes | No |
| 17 | Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication?<br>[Dosing: 400 mg twice 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**

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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

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immediately and destroy this document.

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