Livtencity (maribavir) Prior Authorization Request Form

Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE: ZIP CODE:	
PATIENT INSURANCE ID NUMBER:	·	

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: <u>PRIMETHERAPEUTICS.COM/NOPP</u>

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: ______

PRESCRIBER INFORMATION				
LAST NAME:	FIRST NAME:			
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:			
NPI NUMBER:	DEA NUMBER:			
PHONE NUMBER:	FAX NUMBER:			
STREET ADDRESS:				
CITY:	STATE: ZIP CODE:			
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:			

MEDICATION OR MEDICAL DISPENSING INFORMATION					
MEDICATION NAME:					
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:		
NEW THERAPY	RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:			
DURATION OF THERAPY (SPECIFIC DATES):					

Continued on next page.



Livtencity (maribavir) Prior Authorization Request Form

Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? YES (if yes, complete below) NO MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): DURATION OF THERAPY (SPECIFY DATES): RESPONSE/REASON FOR FAILURE/ALLERGY: 2. UST DIAGNOSES: ICD-10: ICD-10: □ Cytomegaloviral disease (CMV) ICD-10: ICD-10: □ Cytomegaloviral disease (CMV) ICD-10: ICD-10: 3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION. IST is drug being used as part of a clinical trial? Yes □ No Does the member have a documented cytomegalovirus (CMV) infection in whole blood or plasma (i.e., screening value 2.2,730 U/mL in whole blood or >10 U/mL in plasma) in 2 consecutive assessments separated by ≥ 1 day? Yes □ No Does the member have a documented cytomegalovirus (CMV) infection in whole blood or plasma (i.e., screening value 2.2,730 U/mL in whole blood or >10 U/mL in plasma) in 2 consecutive assessments separated by ≥ 1 day? UPS □ No Please provide lab documentation and dates. Does the member have current CMV infection that is refractory to at least 2 anti-CMV treatment agents (e.g., ganciclovir, valganciclovir, cidofovir, or foscarnet)? □ Yes □ No For renewal, additionally answer the following: Does the patient have disease improvement and/or stabilization OR improvement in the slope of decline? □ Yes □ No Doc ther dage dises is important to this review? <th>MEMBER'S LAST NAME:</th> <th colspan="3">MEMBER'S FIRST NAME:</th>	MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:			
DRUG NAME AND DOSAGE): DATES): FAILURE/ALLERGY: 2. LIST DIAGNOSES: ICD-10: ○ Cytomegaloviral disease (CMV) ICD-10; ○ Other diagnosis: ICD-10; 3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRICE AUTORIZATION. Is this drug being used as part of a clinical trial? INFOR AUTORIZATION. Does the member have a documented cytomegalovirus (CMV) infection in whole blood or plasma (i.e., screening value ≥ 2,730 IU/mL in whole blood or > 290 IU/mL in plasma) in 2 consecutive assessments separated by ≥ 1 day? IV Yes No Please provide lab documentation and dates. Does the member have current CMV infection that is refractory to at least 2 anti-CMV treatment agents (e.g., ganciclovir, cidofovir, or foscarnet)? IV yes No Provide documentation and /or stabilization OR improvement in the slope of decline? IV yes No Does the patient have disease improvement and/or stabilization OR improvement in the slope of decline? IV yes No Does the provider attest that the patient is NOT resistant (or a non-responder) to maribavir? Yes No Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review? Important to this review? </td <td>1. HAS THE PATIENT TRIED ANY OTHER</td> <td>R MEDICATIONS FOR THIS CONDITION?</td> <td>YES (if yes, complete below) 📃 NO</td>	1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) 📃 NO		
□ Cytomegaloviral disease (CMV) ICD-10; 3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION. Is this drug being used as part of a clinical trial? □ Yes □ No Has the patient had a solid organ transplant or allogenic hematopoietic stem cell transplantation? □ Yes □ No Does the member have a documented cytomegalovirus (CMV) infection in whole blood or plasma (i.e., screening value ≥ 2,730 U/mL in whole blood or ≥ 101 U/mL in plasma) in 2 consecutive assessments separated by ≥ 1 day? □ Yes □ No Please provide lab documentation and dates. Does the member have current CMV infection that is refractory to at least 2 anti-CMV treatment agents (e.g., ganciclovir, valganciclovir, or foscarnet)? □ Yes □ No Poes the patient have disease improvement and/or stabilization OR improvement in the slope of decline? □ Yes □ No For renewal, additionally answer the following: Does the patient have disease improvement and/or stabilization OR improvement in the slope of decline? □ Yes □ No Documentation and lab values must be provided. Does the provider attest that the patient is NOT resistant (or a non-responder) to maribavir? □ Yes □ No Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?		•	-		
□ Cytomegaloviral disease (CMV) ICD-10; 3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION. Is this drug being used as part of a clinical trial? □ Yes □ No Has the patient had a solid organ transplant or allogenic hematopoietic stem cell transplantation? □ Yes □ No Does the member have a documented cytomegalovirus (CMV) infection in whole blood or plasma (i.e., screening value ≥ 2,730 U/mL in whole blood or ≥ 101 U/mL in plasma) in 2 consecutive assessments separated by ≥ 1 day? □ Yes □ No Please provide lab documentation and dates. Does the member have current CMV infection that is refractory to at least 2 anti-CMV treatment agents (e.g., ganciclovir, valganciclovir, or foscarnet)? □ Yes □ No Poes the patient have disease improvement and/or stabilization OR improvement in the slope of decline? □ Yes □ No For renewal, additionally answer the following: Does the patient have disease improvement and/or stabilization OR improvement in the slope of decline? □ Yes □ No Documentation and lab values must be provided. Does the provider attest that the patient is NOT resistant (or a non-responder) to maribavir? □ Yes □ No Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?			ICD-10-		
 Other diagnosis:					
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRICR AUTHORIZATION. Is this drug being used as part of a clinical trial? Yes No Has the patient had a solid organ transplant or allogenic hematopoietic stem cell transplantation? Yes No Does the member have a documented cytomegalovirus (CMV) infection in whole blood or plasma (i.e., screening value ≥ 2,730 IU/mL in whole blood or ≥ 910 IU/mL in plasma) in 2 consecutive assessments separated by ≥ 1 day? Yes No Please provide lab documentation and dates. Does the member have current CMV infection that is refractory to at least 2 anti-CMV treatment agents (e.g., ganciclovir, valganciclovir, cidofovir, or foscarnet)? Yes No Provide documentation and dates. Does the member have current CMV infection that is refractory to at least 2 anti-CMV treatment agents (e.g., ganciclovir, valganciclovir, cidofovir, or foscarnet)? Yes No For renewal, additionally answer the following: Does the patient have disease improvement and/or stabilization OR improvement in the slope of decline? Yes No Does the provider attest that the patient is NOT resistant (or a non-responder) to maribavir? Yes No Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review? Please note: Not all drugs/diagnosis are covered on al		ICD-10:			
Is this drug being used as part of a clinical trial? □ Yes □ No Has the patient had a solid organ transplant or allogenic hematopoietic stem cell transplantation? □ Yes □ No Does the member have a documented cytomegalovirus (CMV) infection in whole blood or plasma (i.e., screening value ≥ 2,730 IU/mL in whole blood or ≥ 910 IU/mL in plasma) in 2 consecutive assessments separated by ≥ 1 day? □ Yes □ No Please provide lab documentation and dates. Does the member have current CMV infection that is refractory to at least 2 anti-CMV treatment agents (e.g., ganciclovir, valganciclovir, cidofovir, or foscarnet)? □ Yes □ No Provide documentation dates and drugs. Will maribavir be coadministered with ganciclovir or valganciclovir be avoided? □ Yes □ No For renewal, additionally answer the following: Does the patient have disease improvement and/or stabilization OR improvement in the slope of decline? □ Yes □ No Documentation and lab values must be provided. Does the provider attest that the patient is NOT resistant (or a non-responder) to maribavir? □ Yes □ No Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review? Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received. ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.			AL INFORMATION TO SUPPORT A		
Has the patient had a solid organ transplant or allogenic hematopoietic stem cell transplantation? □ Yes □ No Does the member have a documented cytomegalovirus (CMV) infection in whole blood or plasma (i.e., screening value ≥ 2,730 IU/mL in whole blood or ≥ 910 IU/mL in plasma) in 2 consecutive assessments separated by ≥ 1 day? □ Yes □ No Please provide lab documentation and dates. Does the member have current CMV infection that is refractory to at least 2 anti-CMV treatment agents (e.g., ganciclovir, vidganciclovir, cidofovir, or foscarnet)? □ Yes □ No Por renewal, additionally answer the following: Does the patient have disease improvement and/or stabilization OR improvement in the slope of decline? □ Yes □ No Documentation and lab values must be provided. Does the provider attest that the patient is NOT resistant (or a non-responder) to maribavir? □ Yes □ No Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review? Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received. ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	PRIOR AUTHORIZATION.				
Does the member have a documented cytomegalovirus (CMV) infection in whole blood or plasma (i.e., screening value ≥ 2,730 IU/mL in whole blood or ≥ 100 IU/mL in plasma) in 2 consecutive assessments separated by ≥ 1 day? □ Yes □ No Please provide lab documentation and dates. Does the member have current CMV infection that is refractory to at least 2 anti-CMV treatment agents (e.g., ganciclovir, valganciclovir, cidofovir, or foscarnet)? □ Yes □ No Provide documentation dates and drugs. Will maribavir be coadministered with ganciclovir or valganciclovir be avoided? □ Yes □ No For renewal, additionally answer the following: Does the patient have disease improvement and/or stabilization OR improvement in the slope of decline? □ Yes □ No Documentation and lab values must be provided. Does the provider attest that the patient is NOT resistant (or a non-responder) to maribavir? □ Yes □ No Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?	Is this drug being used as part of a clin	ical trial? 🗆 Yes 🗆 No			
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review? Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received. ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	Does the member have a documented cytomegalovirus (CMV) infection in whole blood or plasma (i.e., screening value $\ge 2,730$ IU/mL in whole blood or ≥ 910 IU/mL in plasma) in 2 consecutive assessments separated by ≥ 1 day? \Box Yes \Box No Please provide lab documentation and dates. Does the member have current CMV infection that is refractory to at least 2 anti-CMV treatment agents (e.g., ganciclovir, valganciclovir, cidofovir, or foscarnet)? \Box Yes \Box No Provide documentation dates and drugs. Will maribavir be coadministered with ganciclovir or valganciclovir be avoided? \Box Yes \Box No For renewal, additionally answer the following: Does the patient have disease improvement and/or stabilization OR improvement in the slope of decline?				
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review? Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received. ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	Does the provider attest that the patient is NOT resistant (or a non-responder) to maribavir? — Yes — No				
information is received. ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.					
information is received. ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.					
the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.					
Prescriber Signature or Electronic I.D. Verification: Date: Date:	the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical				
	Prescriber Signature or Electronic I.D.	D. Verification: Date:			



Livtencity (maribavir) Prior Authorization Request Form

Caterpillar Prescription Drug Benefit

Phone: 877-228-7909 Fax: 800-424-7640

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program

Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811

