Prescriber Criteria Form

Livtencity 2026 PA Fax 5092-A v1 010126.docx
Livtencity (maribavir)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Livtencity (maribavir).

Drug Name:
Livtencity (maribavir)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the treatment of post-transplant cytomegalovirus (CMV) infection/disease? [If no, then no further questions.]	Yes	No
2	Is the patient 12 years of age or older? [If no, then no further questions.]	Yes	No
3	Does the patient weigh at least 35 kilograms? [If no, then no further questions.]	Yes	No
4	Is the infection/disease refractory to treatment (with or without genotypic resistance) with any of the following: A) ganciclovir, B) valganciclovir, C) cidofovir, D) foscarnet? [If no, then no further questions.]	Yes	No
5	Is the requested drug being prescribed by or in consultation with any of the following: A) infectious disease specialist, B) transplant specialist, C) hematologist, D) oncologist?	Yes	No

Comments:	

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date:_____