Prescriber Criteria Form
Prevymis 2026 PA Fax 4788-A v1 010126.docx
Prevymis (letermovir)
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 Prevymis (letermovir).

Drug Name:
Prevymis (letermovir)

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 used for prophylaxis of cytomegalovirus (CMV) infection or disease in hematopoietic stem cell transplant? [If no, then skip to question 5.]	Yes	No
2	Is the patient cytomegalovirus (CMV)-seropositive? [If no, then no further question.]	Yes	No
3	Is the patient a recipient of an allogeneic hematopoietic stem cell transplant (HSCT)? [If no, then no further questions.]	Yes	No
4	Is the patient 6 months of age or older? [No further questions.]	Yes	No
5	Is the requested drug being used for prophylaxis of cytomegalovirus (CMV) disease in kidney transplant? [If no, then no further questions.]	Yes	No
6	Is the patient cytomegalovirus (CMV)-seronegative? [If no, then no further questions.]	Yes	No
7	Is the patient a high risk recipient of kidney transplant? [If no, then no further questions.]	Yes	No
8	Is the patient 12 years of age or older?	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:_____