

Effective Date: 9/2019
Last Reviewed: 9/2019, 1/2020, 11/2020, 4/2021, 3/2022
Medical Scope: Medicaid, Commercial, Medicare-Medicaid Plan (MMP)

PREVYMIS (letermovir)

I. INDICATIONS

The indications below including FDA-approved indications and compendia uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication

Prevymis is indicated for prophylaxis of cytomegalovirus (CMV) infection and disease in adult CMV-seropositive recipients [R+] of an allogeneic hematopoietic stem cell transplant (HSCT).

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

An authorization may be granted when the following criteria are met:

- Member is 18 years of age or older; AND
- The requested drug is being prescribed for the prophylaxis of cytomegalovirus (CMV) infection and disease in an adult CMV-seropositive recipient [R+] of an allogeneic hematopoietic stem cell transplant (HSCT) [Documentation must be provided of date of allogeneic HSCT]; AND
- The requested drug must be given within 100 days post-transplant; AND
- If requesting the IV formulation, documentation that the member must not be able to tolerate/swallow the oral tablet; OR
- MMP members who have previously received this medication within the past 365 days are not subject to Step Therapy Requirements

III. DOSING LIMITS

- 480 mg / day

IV. COVERAGE DURATION

- Limited to a maximum of 100 days post-transplant

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V. APPLICABLE CODES

The following HCPCS/CPT codes are:

HCPCS/CPT Code	Description
J3490	Unclassified drugs
C9399	Unclassified drugs or biologicals

VI. REFERENCES

1. Prevymis [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; February 2021.
2. Micromedex (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. <http://www.micromedexsolutions.com/>. Accessed September 2019.