

Effective Date: 9/2019
Last Reviewed: 9/2019, 1/2020, 11/2020, 4/2021, 03/2022, 03/2023, 09/2023, 01/2024
Pharmacy Scope: Medicaid
Medical Scope: Medicaid, Commercial, Medicare-Medicaid Plan (MMP)

PREVYMIS (letermovir) tablets and intravenous injection

MEDICAL POLICY

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 Indications

1. 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).
2. Prevymis is indicated for prophylaxis of CMV disease in adult kidney transplant recipients at high risk (Donor CMV seropositive/Recipient CMV seronegative [D+/R-]).

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], OR
- The requested drug is being prescribed for prophylaxis of CMV disease in adult kidney transplant recipients at high risk (Donor CMV seropositive/Recipient CMV seronegative [D+/R-]). [Documentation must be provided of date of transplant]; 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; AND

III. DOSING LIMITS

- Prevymis 240mg and 480mg tablet: 1 tablet per day
- Prevymis inj 240mg/12ml: 12 ml per day (1 vial per day)
- Prevymis inj 480mg/24ml: 24 ml per day (1 vial per day)

Effective Date: 9/2019
Last Reviewed: 9/2019, 1/2020, 11/2020, 4/2021, 03/2022, 03/2023, 09/2023, 01/2024
Pharmacy Scope: Medicaid
Medical Scope: Medicaid, Commercial, Medicare-Medicaid Plan (MMP)

IV. COVERAGE DURATION

- Limited to a maximum of 100 days post-transplant

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.; August 2023. Accessed November 2023.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2023. <https://online.lexi.com>. Accessed June 16, 2023.
3. Micromedex (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: <https://www.micromedexsolutions.com/> (cited: 06/16/2023).