Effective Date: 9/2019
Last Reviewed: 9/2019, 1/2020, 11/2020, 4/2021, 03/2022, 03/2023, 09/2023, 01/2024, 9/2024, 3/2025 Pharmacy Scope: Medicaid

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 and pediatric patients 6 months of age and older and weighing at least 6 kg who are CMV-seropositive recipients [R+] of an allogeneic hematopoietic stem cell transplant (HSCT).

2. Prevymis is indicated for prophylaxis of CMV disease in adult and pediatric patients 12 years of age and older and weighing at least 40 kg who are 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:

- If the requested drug is being prescribed for the prophylaxis of cytomegalovirus (CMV) infection and disease in CMV-seropositive recipient [R+] of an allogenic hematopoietic stem cell transplant (HSCT) the member must meet all of the following:
    - Documentation the member is 6 months of age or older; **AND**
    - Documentation the member weighs 6 kg or greater; **OR**
- If the requested drug is being prescribed for prophylaxis of CMV disease in kidney transplant recipients at high risk (Donor CMV seropositive/Recipient CMV seronegative [D+/R-]) the member must meet all of the following:
    - Documentation the member is 12 years of age or older; **AND**
    - Documentation member weighs 40 kg or greater; **AND**
- Documentation of the date of allogenic HSCT or date of transplant; **AND**
- Documentation that the requested drug must be given 200 days post-transplant; **AND**
- If requesting the IV formulation, documentation that the member must not be able to tolerate/swallow the oral tablet

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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)
- Prevymis 20 mg and 120 mg oral pellets: 4 packets per day

IV. COVERAGE DURATION

Limited to a maximum of 200 days post-transplant

V. REFERENCES

1. Prevymis [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; January 2025. Accessed March 2025.
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).

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