JOHNS HOPKINS MEDICINE / JOHNS HOPKINS HEALTHCARE	Johns Hopkins HealthCare LLC **Pharmacy Public** **Pharmacy Management Drug Policies**	*Policy Number*	MEDS112
		Effective Date	04/18/2018
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	Subject **Prevymis**	*Revision Date*	12/07/2021
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This document applies to the following Participating Organizations:

Priority Partners

Keywords: prevymis

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I. POLICY

A. Prevymis (letermovir) will require prior authorization to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.
   1. PPMCO members are subject to the Priority Partners formulary, available at www.ppmco.org.
   2. USFHP members are subject to prior authorization criteria, step-edits and days-supply limits outlied in the Tricare Policy Manual. Tricare Policy supersedes JHHC Medical/Pharmacy Policies. Tricare limits may be accessed at: **http://pec.ha.osd.mil/formulary_search.php?submenuheader=1**

II. POLICY CRITERIA

A. Oral Prevymis may be approved for patients meeting the following:
   1. Patient is 18 years of age or older
   2. Documentation has been submitted showing that Prevymis will be used for prophylaxis of cytomegalovirus (CMV) infection and disease in adult CMV-seropositive recipients of an allogenic hematopoietic stem cell transplant (HSCT)
   3. Documentation has been submitted showing the date of HSCT
   4. Therapy will be initiated between Day 0 and Day 28 following HSCT

III. AUTHORIZATION PERIOD/LIMITATIONS

A. Approval will be limited to 100 days post-transplantation

IV. EXCLUSIONS

A. Prevymis is not approved for the following:
   1. concomitant use with pimozide or ergot alkaloids.
   2. co-administration with cyclosporine in conjunction with either pitavastatin or simvastatin.
   3. treatment initiated after Day 28 post-transplantation
   4. treatment exceeding Day 100 post-transplantation
   5. any indications or uses that are not FDA-approved or guideline-supported

B. The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of hte medical and/or pharmacy benefit. All pertinent criteria must be met in order ot be eligible for benefit coverage.

V. REFERENCES

1. Prevymis [prescribing information]. Whitehouse Station, NJ: Merck & Co., Inc. March 2020.

VI. APPROVALS

Signature on file at JHHC

DATE OF REVISION	SUMMARY OF CHANGE
04/18/2018	Policy Creation
07/01/2018	Removed EHP Line of Business
12/07/2021	Updated references

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