UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1246-9
Program	Prior Authorization/Notification
Medication	Prevymis™ (letermovir)
P&T Approval Date	6/2018, 6/2019, 6/2020, 6/2021, 6/2022, 6/2023, 7/2023, 7/2024, 10/2024
Effective Date	1/1/2025

1. Background:

Prevymis (letermovir) is a CMV DNA terminase complex inhibitor 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). Prevymis is also 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-]).[1]

2. Coverage Criteria[a]:

A. Cytomegalovirus Prophylaxis

1. **Initial Therapy**

a. **Prevymis** will be approved based on **one** of the following criteria

(1) **All** of the following:

(a) Patient is a recipient of an allogeneic hematopoietic stem cell transplant

-AND-

(b) Patient is CMV-seropositive

-AND-

(c) Provider attests that Prevymis will be initiated between Day 0 and Day 28 post-transplantation (before or after engraftment) and is being prescribed as prophylaxis and not treatment of CMV infection

-OR-

(2) **All** of the following:

(a) Patient is a recipient of a kidney transplant

-AND-

(b) Patient is CMV-seronegative

-AND-

(c) Donor is CMV-seropositive

-AND-

(d) Provider attests that Prevymis will be initiated between Day 0 and Day 7 post-transplantation (before or after engraftment) and is being prescribed as prophylaxis and not treatment of CMV infection

Authorization will be issued for 9 months.

2. **Reauthorization**

All requests for reauthorization will be **denied by OptumRx**. All requests for continuation of therapy must be submitted through the appeals process to UnitedHealthcare Pharmacy appeals for consideration.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits, Step Therapy, and/or Medical Necessity may be in place.

4. References:

1. Prevymis [package insert]. Rahway, NJ: Merck Sharp & Dohme LLC.; August 2024.

Program	Prior Authorization/Notification – Prevymis (letermovir)
Change Control	
6/2018	New program
6/2019	Annual review with no change to coverage criteria. Updated reference.
6/2020	Annual review with no changes to coverage criteria.
6/2021	Annual review with no changes to coverage criteria.
6/2022	Annual review with no changes to coverage criteria. Updated reference.
6/2023	Annual review with no changes to coverage criteria. Updated reference and added state mandate footnote.
7/2023	Updated background with additional FDA approved indication and

	updated coverage criteria. Updated reference.
7/2024	Annual review with no changes to coverage criteria. Updated reference.
10/2024	Updated background with expanded FDA approved indications in pediatric population. No changes to coverage criteria. Updated reference.