CMV (CYTOMEGALOVIRUS)
QUANTITY LIMIT REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber may complete and fax this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/pharmacy/star-kids-prior-auth

PATIENT AND INSURANCE INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Patient Address:	City, State, Zip:	Patient Telephone:	
BCBSTX ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis- ICD code plus description:

Medication Requested: Strength:

Dosing Schedule: Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested dose of the requested medication? ☐ Yes ☐ No
   If yes, when was treatment with the requested dose started? _____
2. Has information been provided in support of therapy with a higher dose and/or a longer duration for the requested indication? ☐ Yes ☐ No
   If yes, please explain: _____

For Prevymis Requests:

3. Has the patient had an additional allogeneic hematopoietic stem cell transplant (HSCT) and requires initiation of Prevymis? ☐ Yes ☐ No

For Livtencity Requests:

4. Does the patient have a post-transplant CMV infection/disease that is refractory to treatment (with or without genotypic resistance) with ganciclovir, valganciclovir, cidofovir, or foscarnet? ☐ Yes ☐ No
5. Will the patient be using the requested agent in combination with ganciclovir and/or valganciclovir for the requested indication? ☐ Yes ☐ No
6. Please list all other medications the patient will take **in combination** with the requested medication for the treatment of this diagnosis. _____
   _____
7. Please list all reasons for selecting the requested **agent, strength, dosing schedule, and quantity over alternatives** (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). _____
   _____
8. Please list all agents the patient has **previously tried and failed for treatment of this diagnosis** (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products. Please specify start and end dates of drugs tried).
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____

Prescriber or Authorized Signature: _____ **Date:** _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility Authorization does not guarantee payment.

Please fax or mail this form to:
Prime Therapeutics LLC, Clinical Review Department
2900 Ames Crossing Road
Eagan, Minnesota 55121

TOLL FREE
Fax: 877.243.6930 **Phone: 855.457.1200**

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