Effective Date: 12/2019
Reviewed: 9/2019 Scope: Medicaid

PREVYMIS (letermovir)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial 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 Indication
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).

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

An authorization may be granted when all the following criteria are met:

- Member is 18 years of age or older
- The requested drug is being prescribed for the prophylaxis of cytomegalovirus (CMV) infection and disease in an adult CMV-seropositive recipient [R+] of an allogenic hematopoietic stem cell transplant (HSCT) [Documentation must be provided of date of allogenic HSCT]
- The requested drug must be given within 100 days post-transplant
- If requesting the IV formulation, documentation that the member must not be able to tolerate/swallow the oral tablet

III. DOSING LIMITS

- 1 tablet / day

IV. COVERAGE DURATION

- Limited to a maximum of 100 days post-transplant

V. REFERENCES

1. Prevymis [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; November 2017.
2. Micromedex (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. http://www.micromedexsolutions.com/. Accessed September 2019.