Mass General Brigham
Health Plan

Antiviral Agents
Prevymis (letermovir vial)
Effective 01/04/2027

Plan	☒ MassHealth UPPL ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☐ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	Prevymis vial is also available on the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria. Additional agents from this class are available through the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria.		

Overview
Prevymis (letermovir) is a cytomegalovirus (CMV) DNA terminase complex inhibitor indicated for prophylaxis of CMV infection and disease in adult CMV-seropositive recipients [R+] of an allogeneic hematopoietic stem cell transplant (HSCT) and in kidney transplant recipients.

Coverage Guidelines
If member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), submission of medical records documenting that the member is currently receiving treatment with the requested drug, excluding when the product is obtained as samples or via manufacturer's patient assistance programs
OR
Authorization may be granted when all of the following criteria are met:

aHSCT Recipients CMV Prophylaxis
1. Diagnosis of CMV prophylaxis post allogenic hematopoietic stem cell transplantation (HSCT)
2. Prescriber is an infectious disease specialist, hematologist or transplant specialist or consult notes are provided
3. Member is ≥6 months of age
4. Member weight is ≥ 6 kg
5. Appropriate dosing
6. Member is at high risk for CMV reactivation
7. Medical necessity for injection instead of tablet formulation

Kidney Transplant Recipients CMV Prophylaxis
1. Diagnosis of CMV prophylaxis post kidney transplant
2. Prescriber is an infectious disease specialist, hematologist or transplant specialist or consult notes are provided

8. Member is ≥12 years of age
9. Member weight is ≥ 40 kg
10. Member is at high risk for CMV reactivation
11. ONE of the following:
    a. Inadequate response or adverse reaction to valganciclovir
    b. Contraindication to valganciclovir (e.g., documentation of concern for severe myelosuppression)
12. Medical necessity for injection instead of tablet formulation

Solid Organ (Non-kidney, Non-HSCT) Transplant Recipients (off-label use)

1. Diagnosis of CMV prophylaxis post solid organ (non-kidney, non-HSCT) transplant
2. Prescriber is an infectious disease specialist, hematologist or transplant specialist or consult notes are provided
3. Member is ≥12 years of age
4. Member weight is ≥ 40 kg
5. Member is at high risk for CMV reactivation
6. ONE of the following:
    a. Inadequate response or adverse reaction to valganciclovir
    b. Contraindication to valganciclovir (e.g., documentation of concern for severe myelosuppression)
6. Medical necessity for injection instead of tablet formulation

Continuation of Therapy

Reauthorizations are evaluated based on the duration of therapy received:

- If the member has received ≤ 3 months of therapy and continues to be high risk, the request should be approved for an additional 3 months.
- If the member has received ≤ 6 months of therapy and the prescriber documents active CMV viremia (no specific viral threshold needs to be met) or additional clinical rationale for extended therapy (unrelated/mismatched donors, T-cell–depleted grafts, myeloablative conditioning regimens, alemtuzumab therapy, rejection, delayed engraftment or chronic GVHD), the request should be approved for an additional 6 months.

Limitations

1. Initial approvals will be granted for: 6 months (limited to 200 days of therapy)
2. Reauthorizations will be granted for:
    a. **3 months** – if member has received ≤ 3 months of therapy and continues to be high risk
    b. **6 months** – if member has received ≤ 6 months of therapy and the prescriber documents active CMV viremia

References

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Review History

06/25/18 – Reviewed
06/19/19 – Approved by P&T
05/20/2020 – Reviewed and Updated May P&T; references updated; dosing updated to included oral and IV formulation; added started and stabilized statement. Effective 8/1/20.
11/16/2022 – Reviewed for Nov P&T. Separated out MH vs Comm/Exch. No clinical changes
02/08/2023 - Reviewed and updated for Feb P&T. Matched MH criteria. Added Overview table. Added Sitavig criteria and updated Prevymis criteria. Clarified approval durations. Updated references. Effective 4/1/23.
06/14/23 – Reviewed and updated for P&T. Admin update: Clarified that Prevymis vial is available through both pharmacy and medical benefits (dual). Effective 6/30/23
12/13/23 – Reviewed and updated for P&T. Policy update to reflect the removal of brand preferred status from Denavir (penciclovir) and added PA. Effective 1/2/24

05/15/25 – Reviewed and updated for P&T. Updated formatting and references. Approval criteria was updated for Prevymis as it is a recommended first line agent per NCCN guideline recommendations for CMV prophylaxis among patients receiving an allogeneic hematopoietic stem cell transplant. Criteria added for off-label use of Prevymis among members undergoing a solid organ (non-kidney, non-HSCT) transplant. These members will need a trial with valganciclovir prior to Prevymis. Note added that members may bypass valganciclovir if high risk for myelosuppression is documented. Approval durations were updated. Effective 6/1/25
11/4/26 – Reviewed and Updated for P&T. Updated formatting and references. Effective 1/4/27