Clinical Policy: Letermovir (Prevymis)

Reference Number: LA.PHAR.367
Effective Date: 03.01.18
Last Review Date: 02.23
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Please note: This policy is for medical benefit*

Description
Letermovir (Prevymis™) is a cytomegalovirus (CMV) DNA terminase complex inhibitor.

FDA Approved Indication(s)
Prevymis is indicated for prophylaxis of CMV infection and disease in adult CMV-seropositive recipients [R+] of an allogeneic hematopoietic stem cell transplant (HSCT).

Policy/Criteria
Prior authorization is required. *Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy Louisiana Healthcare Connections that Prevymis is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Prophylaxis of CMV Infection in Adult CMV-Seropositive Recipients of an Allogeneic HSCT (must meet all)**:**

1. Member has received or is scheduled to receive allogeneic HSCT;
2. Member is CMV-seropositive;
3. Prescribed by or in consultation with an oncology, hematology, infectious disease, or transplant specialist;
4. Age ≥ 18 years;
5. If request is for IV Prevymis, documentation supports inability to use oral therapy;
6. At the time of request, member is not receiving any of the following contraindicated agents:
   a. Pimozide or ergot alkaloids;
   b. Cyclosporine co-administered with pitavastatin or simvastatin;
7. Dose does not exceed 480 mg per day (240 mg per day if co-administered with cyclosporine).

Approval duration: Through Day 100 post-transplantation

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the PDL (Medicaid), the no coverage criteria policy LA.PMN.255 for Medicaid; or
   b. For drugs NOT on the PDL (Medicaid), the non-formulary policy LA.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53 for Medicaid.

II. Continued Therapy

A. Prophylaxis of CMV Infection in Adult CMV-Seropositive Recipients of an Allogeneic HSCT (must meet all)**:**

1. Currently receiving medication via Louisiana Healthcare Connections, or documentation supports that member is currently receiving for prophylaxis of CMV infection in adult CMV-seropositive recipients [R+] of an allogeneic HSCT and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. Member has not received Prevymis therapy beyond 100 days post-transplantation;
4. If request is for a dose increase, new dose does not exceed 480 mg per day (240 mg per day if co-administered with cyclosporine).

Approval duration: Through Day 100 post-transplantation

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the PDL (Medicaid), the no coverage criteria policy LA.PMN.255 for Medicaid; or
   b. For drugs NOT on the PDL (Medicaid), the non-formulary policy LA.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – LA.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CMV: cytomegalovirus FDA: Food and Drug Administration

HSCT: hematopoietic stem cell transplant R+: seropositive recipients

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): patients receiving any of the following - pimozide, ergot alkaloids, pitavastatin and simvastatin when co-administered with cyclosporine
- Boxed warning(s): none reported

Appendix D: General Information
- Prophylaxis strategy against early CMV replication (i.e., < 100 days after HSCT) for allogeneic recipients involves administering prophylaxis to all allogeneic recipients at risk throughout the period from engraftment to 100 days after HSCT.
  - CMV prophylaxis has been studied using a variety of agents, including ganciclovir, valganciclovir, foscarnet, acyclovir, and valacyclovir.
- Preemptive strategy targets antiviral treatment to those patients who have evidence of CMV replication after HSCT.
- Positive response to therapy may be demonstrated if there is no evidence of CMV viremia.
- The 2021 American Society for Transplantation and Cellular Therapy Guideline for prevention of CMV infection after HCT states that primary prophylaxis in CMV-seropositive adult allogeneic recipients with alternative agents such as valganciclovir, ganciclovir, or foscarnet is generally not recommended.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Prophylaxis of CMV infection in adult CMV-seropositive recipients [R+] of an allogeneic HSCT	480 mg administered once daily PO or as an IV infusion over 1 hour through 100 days post-transplant. If co-administered with cyclosporine, the dosage of should be decreased to 240 mg once daily.	480 mg (or 240 mg when co-administered with cyclosporine) per day

VI. Product Availability
- Tablets: 240 mg, 480 mg
- Single-dose vials: 240 mg/12 mL, 480 mg/24 mL

VII. References
1. Prevymis Prescribing Information. Whitehouse Station, NJ: Merck and Co., Inc.: June 2022. Available at: https://www.merck.com/product/usa/pi_circulars/p/prevymis/prevymis_pi.pdf. Accessed October 24, 2022.
2. Clinical Pharmacology [database online]. Elsevier, Inc.; 2022. Available at: https://www.clinicalkey.com/pharmacology/. Accessed October 24, 2022.

3. Ljungman P, de La Camara R, Milpied N, Volin L, Russell CA, Crisp A, Webster A; Valacyclovir International Bone Marrow Transplant Study Group. Randomized study of valacyclovir as prophylaxis against cytomegalovirus reactivation in recipients of allogeneic bone marrow transplants. Blood. 2002;99:3050-6.
4. Winston DJ, Yeager AM, Chandrasekar PH, Snydman DR, Petersen FB, Territo MC; Valacyclovir Cytomegalovirus Study Group. Randomized comparison of oral valacyclovir and intravenous ganciclovir for prevention of cytomegalovirus disease after allogeneic bone marrow transplantation. Clin Infect Dis. 2003;36:749-58. Epub 2003 Mar 3.
5. Tomblyn M, Chiller T, Einsele H, et al. Guidelines for Preventing Infectious Complications among Hematopoietic Cell Transplantation Recipients: A Global Perspective. Biol Blood Marrow Transplant. 2009; 15: 1143-1238.
6. Boeckh M, Ljungman P. How we treat cytomegalovirus in hematopoietic cell transplant recipients. Blood 2009; 113:5711-9.
7. Schmidt-Hieber, M., Schwarck, S., Stroux, A. et al. Immune reconstitution and cytomegalovirus infection after allogeneic stem cell transplantation: the important impact of in vivo T cell depletion. Int J Hematol (2010) 91: 877-885.
8. Hakki M, Aitken SL, Danziger-Isakov L, et al. American Society for Transplantation and Cellular Therapy Series: #3-Prevention of Cytomegalovirus Infection and Disease After Hematopoietic Cell Transplantation. Transplant Cell Ther. 2021 Sep; 27(9):707-719.

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J3490	Unclassified drugs
J8499	Prescription drug, oral, non chemotherapeutic, nos

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Converted corporate to local policy	02.23	

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

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This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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