

## Ietermovir injection (Prevymis)

### Commercial Medical Benefit Drug Policy

#### Place of Service

Office Administration  
Infusion Center Administration  
Home Infusion Administration  
Hospital Administration  
Outpatient Facility Administration

### Drug Details

**USP Category:** ANTIVIRALS

**Mechanism of Action:** CMV DNA terminase complex inhibitor

#### **HCPCS:**

C9399:Unclassified drugs or biologicals  
J3490:Unclassified drugs

#### **How Supplied:**

- 240 mg/12 mL (20 mg/mL) single-dose vial (NDC 0006-5003-##)
- 480 mg/24 mL (20 mg/mL) single-dose vial (NDC 0006-5004-##)

### Condition(s) listed in policy *(see coverage criteria for details)*

- Cytomegalovirus (CMV) Prophylaxis

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the Health and Safety Code section 1367.21 must be met.

### Special Instructions and Pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

For billing purposes, drugs must be submitted with the drug's assigned HCPCS code (as listed in the drug policy) and the corresponding NDC (national drug code). An unlisted, unspecified, or miscellaneous code should not be used if there is a specific code assigned to the drug.

Members with the following plans: PPO, Direct Contract HMO, and when applicable, ASO, Shared Advantage, HMO (non-direct) may be required to have their medication administered at a preferred site of service, including the home, a physician's office, or an independent infusion center not associated with a hospital.

For members that cannot receive infusions in the preferred home or ambulatory setting AND meet one of the following criteria points, drug administration may be performed at a hospital outpatient facility infusion center.

## **CRITERIA FOR HOSPITAL OUTPATIENT FACILITY ADMINISTRATION**

*MCG Care Guidelines, 19th edition, 2015*

ADMINISTRATION OF THIS DRUG IN THE HOSPITAL OUTPATIENT FACILITY SITE OF CARE REQUIRES ONE OF THE FOLLOWING: (*Supporting Documentation must be submitted*)

1. Patient is starting new therapy with this drug (allowed for 2 weeks). Subsequent doses will require medical necessity for continued use in the hospital outpatient facility site of care.
2. Patient is being re-initiated on this drug after being off therapy for at least 6 months (allowed for 2 weeks). Subsequent doses will require medical necessity for continued use in the hospital outpatient facility site of care.
3. Additional clinical monitoring is required during administration as evidenced by one of the following:
  - a. Patient has experienced a previous severe adverse event on this drug based on documentation submitted.
  - b. Patient continues to experience moderate to severe adverse events on this drug based on documentation submitted, despite receiving premedication such as acetaminophen, steroids, diphenhydramine, fluids, etc.
  - c. Patient is clinically unstable based on documentation submitted.
  - d. Patient is physically or cognitively unstable based on documentation submitted

### **Coverage Criteria**

**The following condition(s) require Prior Authorization/Preservice.**

#### **Cytomegalovirus (CMV) Prophylaxis**

**Meets medical necessity if all the following are met:**

1. Not being covered under the case rate
2. Being used as prophylaxis of CMV infection and disease
3. Meets ONE of the following:
  - a. Recipient of an allogeneic HSCT and meets ALL of the following:
    - i. Diagnosis of CMV-seropositive
    - ii. ONE of the following:
      1. Being used within 100 days post-transplant
      2. Being used through day 200 post-HSCT in patients at risk for late CMV infection and disease
  - b. Recipient of a kidney transplant and meets ALL of the following:
    - i. High risk (Donor CMV seropositive/Recipient CMV seronegative [D+/R-])
    - ii. Being used within 200 days post-transplant
4. Medical reason why the oral formulation of Prevmis cannot be used

#### **Covered Doses:**

Not to exceed 480 mg given intravenously once daily

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**Coverage Period:**

HSCT: 200 days post-transplant

Kidney transplant: 200 days post-transplant

**ICD-10:**

Z94.81

**Additional Information****Pediatric dosing for HSCT recipients**

Recommended daily IV dosage of Prevmis in pediatric HSCT recipients 6 months to less than 12 years of age or 12 yeasts of age and older and weighing less than 30 kg (from Prescribing Information)

Body weight	Daily IV dose
30 kg and above	480 mg
15 kg to less than 30 kg	120 mg
7.5 kg to less than 15 kg	60mg
6 kg to less than 7.5 kg	40 mg

Recommended daily oral dosage of Prevmis in pediatric HSCT recipients 6 months to less than 12 years of age or 12 years of age and older and weighing less than 30 kg (from Prescribing Information)

Body weight	Daily oral dose	Tablets	Oral Pellets ( <i>product availability pending</i> )
30 kg and above	480 mg	One 480 mg tablet or two 240 mg tablets	Four 120 mg packets of oral pellets
15 kg to less than 30 kg	120 mg	One 240 mg tablet	Two 120 mg packets of oral pellets
7.5 kg to less than 15 kg	60mg	Not recommended	One 120 mg packet of oral pellets
6 kg to less than 7.5 kg	40 mg	Not recommended	Four 20 mg packets of oral pellets

**References**

1. AHFS. Available by subscription at <http://www.lexi.com>
2. DrugDex. Available by subscription at <http://www.micromedexsolutions.com/home/dispatch>
3. National Comprehensive Cancer Network. Prevention and Treatment of Cancer-Related Infections (Version 3.2024). Available at <http://www.nccn.org>.
4. Prevmis (letermovir) Prescribing Information. Merck & Co., Rahway, NJ: 8/2024.

**Review History**

Date of Last Annual Review: 1Q2026

Changes from previous policy version:

- No clinical change following annual review.

*Blue Shield of California Medication Policy to Determine Medical Necessity*

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*Reviewed by P&T Committee*