# NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

## Request for Insured Coverage of Maribavir (Livtencity)

| PATIENT INFORMATION | | | |
|---|---|---|---|
| **PATIENT SURNAME** | **PATIENT GIVEN NAME** | **HEALTH CARD NUMBER** | **DATE OF BIRTH** |
| | | | |
| **PATIENT ADDRESS** | | | |
| | | | |

## INITIAL REQUEST

Please advise how the patient meets all of the following criteria:

☐ Post-transplant cytomegalovirus (CMV) infection/disease **AND**

☐ Refractory[1] (with or without genotypic resistance) to 1 or more of the following antiviral therapies: valganciclovir, ganciclovir, foscarnet, or cidofovir.

Please specify: _____

[1]Refractory to an antiviral is defined as a lack of change in CMV viral load or increase in CMV viral load after at least 2 weeks of appropriately dosed treatment.

## RENEWAL REQUEST

Subsequent treatment may be considered for the following:

☐ Patients who have a recurrence of CMV viremia after a previous successful course of therapy with maribavir

**Discontinuation criteria:**

☐ Yes ☐ No No change or an increase in CMV viral load after at least 2 weeks of maribavir treatment **OR**

☐ Yes ☐ No Confirmed CMV genetic mutation associated with resistance to maribavir.

| **PRESCRIBER NAME & ADDRESS:** | | |
|---|---|---|
| | | |
| **LICENCE #** | **PRESCRIBER SIGNATURE** | **DATE** |

**If you need assistance, please contact the Pharmacare Office at (902) 496-7001 or 1-800-305-5026**

**Please Return Form To:** Nova Scotia Pharmacare Programs
P.O. Box 500, Halifax, NS B3J 2S1
Fax: (902) 496-4440



NOVA SCOTIA