

## PRIOR AUTHORIZATION POLICY

**POLICY:** Infectious Disease – Livtency Prior Authorization Policy

- Livtency™ (maribavir tablets – Takeda)

**REVIEW DATE:** 12/11/2024

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### OVERVIEW

Livtency, a protein kinase inhibitor, is indicated for the treatment of **post-transplant cytomegalovirus (CMV) infection/disease** that is refractory to treatment (with or without genotypic resistance) with ganciclovir, valganciclovir, cidofovir, or foscarnet in patients  $\geq 12$  years of age (weighing  $\geq 35$  kg).<sup>1</sup> Co-administration of Livtency with ganciclovir or valganciclovir is not recommended; Livtency may antagonize the antiviral activity of these agents. In the pivotal study (SOLSTICE), patients were treated with Livtency (or another medication) for up to 8 weeks.

CMV infection is a common complication of hematopoietic-cell and solid-organ transplantation and is associated with increased morbidity and mortality.<sup>2</sup> The available antiviral agents (valganciclovir tablets or oral solution, ganciclovir injection, cidofovir injection, and foscarnet injection) are effective but use is limited by their toxic effects. In addition, approximately 5% to 14% of transplant recipients develop infection with drug-resistant CMV, which is associated with poor outcomes.

### POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Livtency. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Livtency as well as the monitoring required for adverse events and long-term efficacy, approval requires Livtency to be prescribed by or in consultation with a physician who specializes in the condition being treated.

**Automation:** None.

### RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Livtency is recommended in those who meet the following criteria:

#### FDA-Approved Indication

**1. Cytomegalovirus Infection – Treatment.** Approve for 2 months if the patient meets ALL of the following (A, B, C, D, E, and F):

- A) Patient is  $\geq 12$  years of age; AND
- B) Patient weighs  $\geq 35$  kg; AND
- C) Patient is post-transplant; AND

Note: This includes patients who are post- hematopoietic stem cell transplant or solid organ transplant.

D) Patient meets ONE of the following (i or ii):

- i. Patient has cytomegalovirus infection/disease that is refractory to treatment with at least one of the following: cidofovir, foscarnet, ganciclovir, or valganciclovir; OR
- ii. Patient has significant intolerance to ganciclovir or valganciclovir; AND

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- E) The medication is not prescribed in conjunction with ganciclovir or valganciclovir; AND
- F) The medication is prescribed by or in consultation with a hematologist, infectious diseases specialist, oncologist, or a physician affiliated with a transplant center.

#### **CONDITIONS NOT RECOMMENDED FOR APPROVAL**

Coverage of Livtencity is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

#### **REFERENCES**

1. Livtencity™ tablets [prescribing information]. Lexington, MA: Takeda; March 2024.
2. Maertens J, Cordonnier C, Jaksch P, et al. Maribavir for preemptive treatment of cytomegalovirus reactivation. *N Engl J Med.* 2019;381:1136-1147.