Updated: 06/2021
DMMA Approved: 06/2021

Request for Prior Authorization for Atovaquone
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Atovaquone require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Atovaquone Prior Authorization Criteria:

For all requests for Atovaquone all of the following criteria must be met:

- Documentation the member is immunocompromised (i.e. HIV, organ transplantation, on immune-suppressive drugs)
- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to trimethoprim-sulfamethoxazole (TMP-SMX)
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Coverage may be provided for the prevention of Pneumocystis pneumonia (PCP)

- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
  - Documentation of clinical benefit and continued need for prophylaxis treatment
- **Reauthorization Duration of approval:** 12 months

Coverage may be provided with a diagnosis of mild-to-moderate Pneumocystis pneumonia (PCP) for treatment

- **Duration of Approval:** 1 month

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

Highmark Delaware HEALTH OPTIONS

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ATOVAQUONE
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:00am to 7:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Health Options ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Does the member have an allergy or contraindication to trimethoprim-sulfamethoxazole (TMP-SMX)?
☐ Yes, please explain: _____
☐ No

Is the member immunocompromised?
☐ Yes, please explain: _____
☐ No

Diagnosis:
☐ **Prevention of Pneumocystis pneumonia (PCP),** ICD-10:_____
☐ **Treatment of mild-moderate Pneumocystis pneumonia (PCP),** ICD-10:_____
☐ Other: _____ ICD-10:_____

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced clinical benefit? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date