Gateway Health It's Wholecare.

Updated: 06/2021
PARP Approved: 06/2021

Gateway Health
Prior Authorization Criteria
Daraprim (pyrimethamine)

All requests for Daraprim (pyrimethamine) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Daraprim (pyrimethamine) Prior Authorization Criteria:

Daraprim (pyrimethamine) is not covered for the treatment or prophylaxis of malaria. Pyrimethamine is not included in the U.S. Centers for Disease Control and Prevention (CDC) recommendations for the prevention or treatment of malaria.

Coverage may be provided with a diagnosis of toxoplasmosis and the following criteria is met:

- Must be used in combination with leucovorin AND a sulfonamide, unless the member had an intolerance or contraindication or has had an inadequate response to a sulfonamide
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:**
  - Acquired toxoplasmosis: 2 months
  - Congenital toxoplasmosis: 12 months
- **Reauthorization Criteria:**
  - See initial criteria
- **Reauthorization Duration of Approval:**
  - Acquired toxoplasmosis: 2 months
  - Congenital toxoplasmosis: 12 months

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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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DARAPRIM (PYRIMETHAMINE) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:

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)

Diagnosis: ☐ Acquired toxoplasmosis ☐ Congenital toxoplasmosis ICD-10: _____
☐Other: _____ ICD-10: _____

Is this being used in combination with leucovorin and a sulfonamide? ☐ Yes ☐ No
If no, please explain:

CURRENT or PREVIOUS THERAPY

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date