HIGHMARK HEALTH OPTIONS

Updated: 05/2025
DMMA Approved: 05/2025

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

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.

- Claims will pay at the point of sale when either of the following is met:
  - A diagnosis of toxoplasmosis is entered at the point of sale
  - For any request that does not meet automatic point of sale approval documentation must be provided that the member has a diagnosis of toxoplasmosis
- **Initial Duration of Approval: 12 months**
- **Reauthorization Criteria:**
  - See initial criteria

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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 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:	
Member 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)

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

CURRENT or PREVIOUS THERAPY

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date