Updated: 08/2020
DMMA Approved: 08/2020

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.

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.

Highmark Delaware HEALTH OPTIONS

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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 8:30am to 5:00pm

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: _____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