HIGHMARK WHOLECARE

Updated: 07/2026
PARP Approved:06/23/2026

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) 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

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 Highmark Wholecare Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (800) 392-1147 Mon – Fri 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
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:	

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, 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:	ICD Code:

CURRENT or PREVIOUS THERAPY

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date