OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY/MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process**.

Drug Requested: **Daraprim®** (pyrimethamine)

DRUG INFORMATION: Complete information below or authorization process will be delayed

Drug Form/Strength: ____

Dosing Schedule: ______________________________ **Length of Therapy:** ____________________

Diagnosis: ____ **ICD Code, if applicable:** ____________

Length of Authorization: **Initial Treatment = 6 weeks; Continuation of therapy = up to 6 months**

CLINICAL CRITERIA: **ALL** criteria **MUST** be checked to qualify. Chart notes **MUST** be submitted with prior authorization form. Incomplete information will delay authorization process.

- ❑ **Toxoplasmosis – Primary Prophylaxis**
  - ❑ Patient must have a diagnosis of HIV/AIDS
  - ❑ Patient must have a CD4 count < 100 cells/mm3
  - ❑ Patient must test positive for Toxoplasmosis gondii IgG antibodies
  - ❑ **Intolerance** to recommended **first line agent TMP-SMX** (trimethoprim-sulfamethoxazole); and TMP-SMX **desensitization** has been attempted: description of specific intolerance to TMP-SMX **must** be documented in progress notes
- ❑ **Toxoplasmosis – Treatment**
  - ❑ Diagnosis made by and infectious disease specialist, neurologist, or HIV specialist
  - ❑ Patient with a diagnosis of HIV/AIDS must have a CD4 count of < 100 cells/mm3
  - ❑ Clinical syndrome of headache, fever, and neurological symptoms must be present
  - ❑ Submission of positive serum testing for Toxoplasmosis gondii IgG antibodies
  - ❑ Brain imaging (CT or MRI) demonstrating lesions
- ❑ **Toxoplasmosis – Chronic Maintenance Therapy**
  - ❑ Patient has completed at least six weeks of active treatment for AIDS-related toxoplasmosis **(Pharmacy Paid Claims will be reviewed)**
  - ❑ CT scan or MRI documents improvement in ring-enhancing lesions prior to initiating maintenance therapy
  - ❑ Patient has documented improvement in clinical symptoms

(Continued on next page; signature MUST be included with this request form)

(Signature page MUST be included with this request form)

Medication being provided by a Specialty Pharmacy - Sentara Norfolk General CM Pharmacy

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: ____

Member Optima #: ______________________ Date of Birth: ______________

Prescriber Name: ____

Prescriber Signature: ______________________ Date: ______________

Office Contact Name: ______________________________________

Phone Number: ______________________ Fax Number: ______________

DEA OR NPI #: ____

***REVISED/UPDATED:** ~~8/26/2017;~~ **8/17/2018**