

OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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. If incomplete, 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

(signature on next page)

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