OPTIMA HEALTH PLAN

PHARMACY 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. 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*:**	❑ **Briova SpecialtyRx**

*****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 #: _____

***Approved by Pharmacy and Therapeutics Committee:** 9/15/2016
REVISED/UPDATED: ~~12/12/2016; 9/13/2017;~~ **10/6/2017**