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* (check applicable box below):**

- ❑ **For Optima Commercial Members:**
  PropriumRx
- ❑ **For Optima Family Care Members:**
  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 #: ____

***Approved by Pharmacy and Therapeutics Committee:** 9/15/2016
REVISED/UPDATED: ~~12/12/2016;~~ **8/3/2017**