Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Daraprim® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Primary prophylaxis of toxoplasmosis
❑ Treatment of toxoplasmosis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

For primary prophylaxis of toxoplasmosis, answer the following:

Does the patient have a diagnosis of HIV/AIDS? ❑ **Yes** ❑ **No**
Does the patient have a CD4 count less than 100 cells/mm^3? ❑ **Yes** ❑ **No**
Has the patient tested positive for *Toxoplasmosis gondii* IgG antibodies? ❑ **Yes** ❑ **No**
Does the patient have intolerance to recommended first line agent TMP-SMX (trimethoprim-sulfamethoxazole) and TMP-SMX desensitization has been attempted? ❑ **Yes** ❑ **No**
Description of specific intolerance to TMP-SMX must be documented in progress notes

For treatment of toxoplasmosis, answer the following:

Select if the patient's diagnosis was made by one of the following specialists:
- ❑ HIV specialist
- ❑ Infectious disease specialist
- ❑ Neurologist

Does the patient have a diagnosis of HIV/AIDS? ❑ **Yes** ❑ **No**
Does the patient have a CD4 count less than 100 cells/mm^3? ❑ **Yes** ❑ **No**
Are clinical syndrome of headache, fever, and neurological symptoms present? ❑ **Yes** ❑ **No**
Has the patient tested positive for *Toxoplasmosis gondii* IgG antibodies? ❑ **Yes** ❑ **No**
Submission of positive serum testing is required
Does the patient have brain imagine (CT or MRI) demonstrating lesions? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following:

Has the patient completed at least six weeks of active treatment for AIDS-related toxoplasmosis? ❑ **Yes** ❑ **No**
Does the patient have CT scan or MRI documenting an improvement in ring-enhancing lesions prior to initiating maintenance therapy? ❑ **Yes** ❑ **No**
Does the patient have documented improvement in clinical symptoms? ❑ **Yes** ❑ **No**

Medication being provided by: (Please check applicable box below)

❑ PropriumRx ❑ Specialty Pharmacy (specify name): _____

Daraprim® Prior Authorization Request Form (Page 2 of 2)

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****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.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.