PRIOR AUTHORIZATION REQUEST
Daraprim

PATIENT: Name______________________
Address: ______________________
City, State, Zip_____________________
D.O.B. _____________________
Member ID:________________________

Prescriber: Name______________________
Address ______________________
City, State, Zip_____________________
Phone _____________________
Fax _____________________
NPI _____________________

Medication Requested:___________ Qty Requested: ___________

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. ☐ Yes ☐ No Is this request for the ACUTE treatment of Toxoplasmosis in a patient with HIV?
   If NO, please proceed to question 3
2. ☐ Yes ☐ No Has the patient already received 6 weeks of treatment for the current infection?
   If NO, please document treatment start date : [_______________]
3. ☐ Yes ☐ No Is this request for secondary prevention of Toxoplasmosis in a patient with HIV?
4. Does the patient have ANY of the following reasons to continue secondary prophylaxis: A) has symptoms of Toxoplasmosis, B) is NOT receiving antiretroviral therapy (ART), C) has evidence of HIV replication (viral load greater than 50 copies/mL), D) has NOT maintained a CD4 count greater than 200 cells/microliter for at least six months?
   - ☐ has symptoms of Toxoplasmosis,
   - ☐ is NOT receiving antiretroviral therapy (ART),
   - ☐ has evidence of HIV replication (viral load greater than 50 copies/mL),
   - ☐ has NOT maintained a CD4 count greater than 200 cells/microliter for at least six months
   - ☐ None of above.
5. ☐ Yes ☐ No Is this request for the prevention of Pneumocystis Pneumonia (PCP) in a patient with HIV? If **NO, please proceed to question 11**
6. ☐ Yes ☐ No Is this request for a renewal of therapy?
7. Does the patient have ONE of the following: A) CD4 count less than 200 cells/microliter OR less than 14%, B) Oropharyngeal candidiasis, C) CD4 cell count of 200-250 cells/microliter but frequent lab monitoring is not possible?
   - ☐ CD4 count less than 200 cells/microliter OR less than 14%
   - ☐ Oropharyngeal candidiasis
   - ☐ CD4 cell count of 200-250 cells/microliter but frequent lab monitoring is not possible
   - ☐ None of above.

If you have any questions, call: 800-753-2851

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8. ☐ Yes ☐ No Has the patient had a trial and failure of atovaquone AND dapsone? ☐If YES, please answer question 10
9. ☐ Yes ☐ No Does the patient have a contraindication to BOTH atovaquone AND dapsone?
10. ☐ Yes ☐ No Is the patient allergic to sulfa or has another contraindication to trimethoprim/sulfamethoxazole (TMP/SMX)?
11. ☐ Yes ☐ No Is this request for the treatment of active Pneumocystis Pneumonia (PCP)?
12. ☐ Yes ☐ No Has the patient had a trial and failure to atovaquone OR does the patient have a contraindication to atovaquone?

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B Physician Signature

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PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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If you have any questions, call: 800-753-2851