PRIOR AUTHORIZATION REQUEST

Daraprim

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request for the ACUTE treatment of Toxoplasmosis in a patient with human immunodeficiency virus (HIV)? [If no, skip to question 4.]	Yes	No
2	Has the patient already received 6 weeks of treatment for the current infection? If no, please document treatment start date: _____. [If no, no further questions.]	Yes	No
3	Is this request for secondary prevention of Toxoplasmosis in a patient with human	Yes	No

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	immunodeficiency virus (HIV)? [If yes, skip to question 5.] [If no, no further questions.]		
4	Is this request for secondary prevention of Toxoplasmosis in a patient with human immunodeficiency virus (HIV)? [If no, skip to question 6.]	Yes	No
5	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 human immunodeficiency virus (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? [No further questions.]	Yes	No
6	Is this request for the prevention of Pneumocystis Pneumonia (PCP) in a patient with human immunodeficiency virus (HIV)? [If no, skip to question 13.]	Yes	No
7	Is this request for a renewal of therapy? [If no, skip to question 9.]	Yes	No
8	Does the patient have a CD4 count less than 200 cells/microliter OR a CD4 count less than 14%? [No further questions.]	Yes	No
9	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 to 250 cells/microliter but frequent lab monitoring is not possible? [If no, no further questions.]	Yes	No
10	Has the patient had a trial and failure of atovaquone AND dapsone? [If yes, skip to question 12.]	Yes	No
11	Does the patient have a contraindication to BOTH atovaquone AND dapsone? [If no, no further questions.]	Yes	No
12	Is the patient allergic to sulfa or has another contraindication to trimethoprim/sulfamethoxazole (TMP/SMX)? [No further questions.]	Yes	No
13	Is this request for the treatment of active Pneumocystis Pneumonia (PCP)? [If no, no further questions.]	Yes	No
14	Has the patient had a trial and failure to atovaquone OR does the patient have a contraindication to atovaquone? [If no, no further questions.]	Yes	No

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15	Is the patient allergic to sulfa or has another contraindication to trimethoprim/sulfamethoxazole (TMP/SMX)?	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

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 authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 1-888-258-8250