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 an INITIAL or CONTINUATION of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

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3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has experienced a clinically significant response as determined by the provider? [No further questions.]	Yes	No
7	What is the indication or diagnosis? [] ACUTE treatment of Toxoplasmosis in a patient with human immunodeficiency virus (HIV) (If checked, go to 8) [] Secondary prevention of Toxoplasmosis in a patient with human immunodeficiency virus (HIV) (If checked, go to 10) [] Prevention of Pneumocystis Pneumonia (PCP) in a patient with human immunodeficiency virus (HIV) (If checked, go to 12) [] Treatment of active Pneumocystis Pneumonia (PCP) (If checked, go to 17) [] Other (If checked, no further questions)		
8	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
9	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dosing is 200 mg as a single dose, followed by 50 mg once daily (patient weight less than or equal to 60 kg) or 75 mg once daily (patient weight greater than 60 kg). [No further questions.]	Yes	No
10	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? [If no, no further questions.]	Yes	No

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11	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dosing is 25 mg once daily. [No further questions]	Yes	No
12	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
13	Has the patient had a trial and failure of atovaquone AND dapsone? [If yes, skip to question 15.]	Yes	No
14	Does the patient have a contraindication to BOTH atovaquone AND dapsone? [If no, no further questions.]	Yes	No
15	Is the patient allergic to sulfa or has another contraindication to trimethoprim/sulfamethoxazole (TMP/SMX)? [If no, no further questions.]	Yes	No
16	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dosing is 50 or 75 mg once weekly. [No further questions]	Yes	No
17	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
18	Is the patient allergic to sulfa or has another contraindication to trimethoprim/sulfamethoxazole (TMP/SMX)? [If no, no further questions.]	Yes	No
19	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dosing is 1 mg/kg daily.	Yes	No

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

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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.

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