SENTARA COMMUNITY PLAN
(MEDICAID)

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. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Daraprim® (pyrimethamine)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Length of Authorization: Initial Treatment = 6 weeks
Continuation of therapy = up to 6 months

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ **Toxoplasmosis – Primary Prophylaxis**
  - ❑ Member must have a diagnosis of HIV/AIDS
  - ❑ Member must have a CD4 count < 100 cells/mm3
  - ❑ Member 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

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- **Toxoplasmosis – Treatment**
  - Diagnosis made by and infectious disease specialist, neurologist, or HIV specialist
  - Member 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**
  - Member 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
  - Member has documented improvement in clinical symptoms

Medication being provided by a Specialty Pharmacy - 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.****

***REVISED/UPDATED:** ~~8/26/2017;~~ ~~8/17/2018;01/29/2020;~~ **11/8/2023**