



Fax completed prior authorization request form to 855-247-3677 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/rbha-forproviders/pharmacy

Pyrimethamine (Daraprim) Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification to support diagnosis

Member Information					
Member Name (first & last):	Date of Birth:	Gender:		Height:	
		<input type="checkbox"/> Male	<input type="checkbox"/> Female		
Member ID:	City:	State:		Weight:	
Prescribing Provider Information					
Provider Name (first & last):	Specialty:	NPI#	DEA#		
Office Address:	City:	State:		Zip Code:	
Office Contact:		Office Phone		Office Fax:	
Dispensing Pharmacy Information					
Pharmacy Name:		Pharmacy Phone:		Pharmacy Fax:	
Requested Medication Information					
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No		Diagnosis:		ICD-10 Code:	
Are there any contraindications to formulary medications? If yes, please specify:		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request	<input type="checkbox"/> Continuation of therapy request
Directions for Use:		Strength:		Dosage Form:	
		Quantity:	Day Supply:	Duration of Therapy/Use:	
What medication(s) has the member tried and failed for this diagnosis? Please specify below.					
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> Urgent – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.			
Signature: _____					
Clinical Information					
Will pyrimethamine be used in combination with a sulfonamide AND leucovorin?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will pyrimethamine be used in combination with leucovorin ONLY?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<input type="checkbox"/> Toxoplasmosis Encephalitis – Primary Prophylaxis					
Does member have HIV with CD4 count < 100 cells/microL?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member seropositive for anti-toxoplasma IgG?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Does member have intolerance or contraindication to trimethoprim-sulfamethoxazole? (for non-life-threatening reactions, the national AIDS guideline recommends re-challenge)				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal ONLY					
Was member complaint to treatment AND lab results support CD4 count?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Toxoplasmosis Encephalitis – Treatment, HIV Associated					
Does member have HIV with CD4 count < 100 cells/microL?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member seropositive for anti-toxoplasma IgG?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Do MRI or CT results support CNS lesions?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Toxoplasmosis Encephalitis - Chronic Maintenance Therapy (Secondary Treatment / Secondary Prophylaxis)					
Has member successfully completed 6 weeks of initial therapy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there documented improvement in clinical symptoms?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No		

Does MRI or CT indicate improvement in ring enhancing lesions, prior to start of maintenance therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has Antiretroviral Therapy been initiated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Acquired and Congenital Toxoplasmosis - Treatment (Non-HIV Related)

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ Date: _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 800-564-5465 to check the status of a request.