Prescriber Criteria Form

Daraprim 2025 PA Fax 1395-A v1 010125.docx
Daraprim (pyrimethamine), Pyrimethamine
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Daraprim.

Drug Name (select from list of drugs shown):

| | | |
|---|---|---|
| **Patient Name:** | | |
| **Patient ID:** | | |
| **Patient DOB:** | **Patient Phone:** | |
| **Prescriber Name:** | | |
| **Prescriber Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Prescriber Phone:** | **Prescriber Fax:** | |
| **Diagnosis**: | **ICD Code(s):** | |

| **Please circle the appropriate answer for each question.** | | | |
|---|---|---|---|
| 1 | Is the requested drug being prescribed for the treatment of congenital toxoplasmosis?<br>[If yes, then no further questions.] | Yes ◯ | No ◯ |
| 2 | Is the requested drug being prescribed for the treatment of toxoplasmosis?<br>[If yes, then no further questions.] | Yes ◯ | No ◯ |
| 3 | Is the requested drug being prescribed for the secondary prophylaxis of toxoplasmosis?<br>[If yes, then skip to question 11.] | Yes ◯ | No ◯ |
| 4 | Is the requested drug being prescribed for any of the following: A) primary prophylaxis of toxoplasmosis, B) prophylaxis of pneumocystis jirovecii pneumonia (PCP)?<br>[If no, then skip to question 7.] | Yes ◯ | No ◯ |
| 5 | Has the patient experienced an intolerance or does the patient have a contraindication to trimethoprim-sulfamethoxazole (TMP-SMX)?<br>[If no, then no further questions.] | Yes ◯ | No ◯ |
| 6 | Has the patient had a CD4 cell count less than 200 cells per cubic millimeter within the past 3 months?<br>[No further questions.] | Yes ◯ | No ◯ |

| | | | |
|---|---|---|---|
| 7 | Is the requested drug being prescribed for the treatment of cystoisosporiasis?<br>[If no, then skip to question 9.] | Yes ◯ | No ◯ |
| 8 | Has the patient experienced an intolerance or does the patient have a contraindication to trimethoprim-sulfamethoxazole (TMP-SMX)?<br>[No further questions.] | Yes ◯ | No ◯ |
| 9 | Is the requested drug being prescribed for the secondary prophylaxis of cystoisosporiasis?<br>[If no, then no further questions.] | Yes ◯ | No ◯ |
| 10 | Has the patient experienced an intolerance or does the patient have a contraindication to trimethoprim-sulfamethoxazole (TMP-SMX)?<br>[If no, then no further questions.] | Yes ◯ | No ◯ |
| 11 | Has the patient had a CD4 cell count less than 200 cells per cubic millimeter within the past 6 months? | Yes ◯ | No ◯ |

| | |
|---|---|
| Comments: | _____ |

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

**Prescriber (or Authorized) Signature:** _____ **Date:**_____