Prescriber Criteria Form Mepron 2025 PA Fax 3620-A v2 010125.docx Mepron (atovaquone oral suspension) 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 Mepron (atovaquone oral suspension).

Drug Name: Mepron (atovaquone oral suspension)

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 toxoplasmosis? [If yes, then no further questions.]	Yes ◯	No ◯
2	Is the requested drug being prescribed for the treatment of mild-to-moderate pneumocystis jirovecii pneumonia (PCP)? [If yes, then skip to question 5.]	Yes ◯	No ◯
3	Is the requested drug being prescribed for any of the following: A) the prevention of pneumocystis jirovecii pneumonia (PCP), B) primary prophylaxis of toxoplasmosis? [If no, then skip to question 6.]	Yes ◯	No ◯
4	Is the patient immunocompromised? [If no, then no further questions.]	Yes ◯	No ◯
5	Has the patient had an intolerance or does the patient have a contraindication to sulfamethoxazole/trimethoprim (SMX-TMP)? [No further questions.]	Yes ◯	No ◯
6	Is the requested drug being prescribed for secondary prophylaxis of toxoplasmosis? [If no, then skip to question 8.]	Yes ◯	No ◯
7	Is the patient immunocompromised? [No further questions.]	Yes ◯	No ◯

8	Is the requested drug being prescribed for the treatment of babesiosis? [If no, then no further questions.]	Yes ◯	No ◯
9	Will the requested drug be used concurrently with azithromycin?	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:**_____