mercy care

Fax completed prior authorization request form to 800-854-7614 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/completecare-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: ☐ Male ☐ Female	Height:
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:	☐ Yes	☐ No	☐ New request	☐ 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	
☐ Standard – (24 hours)	☐ **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?	☐ Yes	☐ No	Will pyrimethamine be used in combination with leucovorin ONLY?	☐ Yes	☐ No
☐ **Toxoplasmosis Encephalitis – Primary Prophylaxis**					
Does member have HIV with CD4 count < 100 cells/microL?	☐ Yes	☐ No	Is member seropositive for anti-toxoplasma IgG?	☐ Yes	☐ No
Does member have intolerance or contraindication to trimethoprim-sulfamethoxazole? (for non-life-threatening reactions, the national AIDS guideline recommends re-challenge)				☐ Yes	☐ No
☐ **Renewal ONLY**					
Was member complaint to treatment AND lab results support CD4 count?				☐ Yes	☐ No
☐ **Toxoplasmosis Encephalitis – Treatment, HIV Associated**					
Does member have HIV with CD4 count < 100 cells/microL?	☐ Yes	☐ No	Is member seropositive for anti-toxoplasma IgG?	☐ Yes	☐ No
Do MRI or CT results support CNS lesions?				☐ Yes	☐ No
☐ **Toxoplasmosis Encephalitis - Chronic Maintenance Therapy (Secondary Treatment / Secondary Prophylaxis)**					
Has member successfully completed 6 weeks of initial therapy?	☐ Yes	☐ No	Is there documented improvement in clinical symptoms?	☐ Yes	☐ No

Does MRI or CT indicate improvement in ring enhancing lesions, prior to start of maintenance therapy?	☐ Yes	☐ No	Has Antiretroviral Therapy been initiated?	☐ Yes	☐ No

☐ **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 800-624-3879 to check the status of a request.