Prescriber Criteria Form Daraprim 2026 PA Fax 1395-A v1 010126.docx Daraprim (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 (pyrimethamine).

Drug Name: Daraprim (pyrimethamine)

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? [If yes, then no further questions.]	Yes	No
2	Is the requested drug being prescribed for the treatment of toxoplasmosis? [If yes, then no further questions.]	Yes	No
3	Is the requested drug being prescribed for the secondary prophylaxis of toxoplasmosis? [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)? [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)? [If no, then no further questions.]	Yes	No
6	Is the patient immunocompromised? [No further questions.]	Yes	No
7	Is the requested drug being prescribed for the treatment of cystoisosporiasis? [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)? [No further questions.]	Yes	No
9	Is the requested drug being prescribed for the secondary prophylaxis of cystoisosporiasis? [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)? [If no, then no further questions.]	Yes	No
11	Is the patient immunocompromised?	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:**_____