OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Daraprim® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
❑ Malaria
❑ Toxoplasmosis
❑ Other diagnosis: ____ ICD-10 Code(s): _______________________________________

Provider's Specialty:
Is Daraprim prescribed by or in consultation with an infectious disease specialist? ❑ **Yes** ❑ **No**

For malaria, answer the following:
Select what Daraprim will be used for:
- ❑ Treatment of acute malaria
- ❑ Chemoprophylaxis of malaria

Does the patient have megaloblastic anemia due to folate deficiency? ❑ **Yes** ❑ **No**
Does the provider acknowledge that Daraprim is not recommended by the Centers for Disease Control and Prevention (CDC) for the treatment and/or prophylaxis of malaria? ❑ **Yes** ❑ **No**

For toxoplasmosis, answer the following:
Is this request for continuation of prior therapy? ❑ **Yes** ❑ **No**
Select what Daraprim will be used for:
- ❑ Treatment of toxoplasmic encephalitis
- ❑ Treatment of congenital toxoplasmosis
- ❑ Secondary prophylaxis of toxoplasmic encephalitis
- ❑ Primary prophylaxis of toxoplasmic encephalitis

For primary prophylaxis of toxoplasmic encephalitis, also answer the following:
Has the patient experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX)? ❑ **Yes** ❑ **No**
Has the patient been re-challenged with TMP-SMX using a desensitizing protocol and is still unable to tolerate? ❑ **Yes** ❑ **No**
Is there evidence the patient has had a life-threatening reaction to TMP-SMX in the past (e.g., toxic epidermal necrolysis [TEN], Stevens-Johnson syndrome)? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?
____

____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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