



Fax completed prior authorization request form to 855-296-0323 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

Aetna Better Health®

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/newjersey/providers/pharmacy

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: | | Height: | |
| | | <input type="checkbox"/> Male | <input type="checkbox"/> Female | | |
| 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: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New request | <input type="checkbox"/> 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 | | | | | |
| <input type="checkbox"/> Standard – (24 hours) | | <input type="checkbox"/> 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 Daraprim be used in combination with a sulfonamide AND leucovorin? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Will Daraprim be used in combination with leucovorin ONLY? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Toxoplasmosis Encephalitis – Primary Prophylaxis | | | | | |
| Does member have HIV with CD4 count < 100 cells/microL? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is member seropositive for anti-toxoplasma IgG? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does member have intolerance or contraindication to trimethoprim-sulfamethoxazole? (for non-life-threatening reactions, the national AIDS guideline recommends re-challenge) | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Renewal Only | | | | | |
| Was member complaint to treatment AND lab results support CD4 count? | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Toxoplasmosis Encephalitis – Treatment, HIV Associated | | | | | |
| Does member have HIV with CD4 count < 100 cells/microL? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is member seropositive for anti-toxoplasma IgG? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do MRI or CT results support CNS lesions? | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Toxoplasmosis Encephalitis - Chronic Maintenance Therapy (Secondary Treatment / Prophylaxis) | | | | | |
| Has member successfully completed 6 weeks of initial therapy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is there documented improvement in clinical symptoms? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does MRI or CT indicate improvement in ring enhancing lesions, prior to start of maintenance therapy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Has Antiretroviral Therapy been initiated? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Congenital Toxoplasmosis - Treatment (Non-HIV Related) | | | | | |
| Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records. | | | | | |

[Empty box for notes or signature]

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 855-232-3596 to check the status of a request.