DISTRICT OF COLUMBIA ~ DEPARTMENT OF HEALTH ~ ADAP

Pyrimethamine (Daraprim®) tablets

PRIOR AUTHORIZATION PROGRAM Request Form

CLIENT'S NAME: _____ ADAP ID: _____

CLIENT'S DATE OF BIRTH: _____ ADAP Pharmacy: _____

DC ADAP Policy: Daraprim® (pyrimethamine) is an antiparasitic compound that inhibits the enzyme dihydrofolic acid; this leads to the disruption of protein synthesis and nuclear division. Pyrimethamine is available for oral administration as a 25mg scored tablet.
Daraprim® requires prior approval for coverage. Allow up to 96 hours for completion of request.

Indication for Use:
Daraprim® is indicated in combination with a sulfonamide and leucovorin for the treatment of congenital and acquired infections of Toxoplasmosis.

Criteria for use:
Please complete and check all that apply:

1. Medical Provider is experienced in the care of HIV/opportunistic infections, or in consultation with an infectious disease specialist.

   YES ☐ NO ☐
2. Does client have adherence issues with antiretrovirals or other medications?

   YES ☐ NO ☐
3. Does client have a history of a sulfa allergy?

   YES ☐ NO ☐
   Describe allergy_____
4. Has the client been tested for G6PD deficiency?

   YES ☐ NO ☐
   Results_____
5. Does client have a concurrent prescription for sulfadiazine and leucovorin?

   YES ☐ NO ☐
6. Does the client have documented seropositivity for anti-toxoplasma immunoglobulin G (IgG) antibodies?

   YES ☐ NO ☐
7. Does the client have CT, MRI or other radiographic testing identifying one or more mass lesions and detection of Toxoplasmosis Encephalitis in a clinical sample?

   YES ☐ NO ☐
8. Does the client have history of inadequate response to TMP/SMZ treatment?

   YES ☐ NO ☐

Recommended dosage and administration: The recommended dosage of Daraprim® (pyrimethamine) for adults is 200mg once, then 50 to 75mg orally once daily. Treatment duration is at least 6 weeks. Longer courses of treatment may be warranted based on clinical response or radiologic findings.

Physician's signature: _____ Date:_____

Physician's Name (Print):_____Phone #:_____Fax #:_____

Fax Completed Form to Clinical Pharmacy Associates, Inc.

Fax: 1 (888) 971-7229 Phone: 1 (800) 745-0434 ext 150 Attention: Prior Approval Program