Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Pyrimethamine - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is pyrimethamine being prescribed by or in consultation with an infectious disease specialist? If YES, go to 2.

☐ Yes ☐ No

Q2. Is documentation attached showing an inadequate response, intolerance, or contraindication to trimethoprim-sulfamethoxazole? If YES, go to 3.

☐ Yes ☐ No

Q3. Is pyrimethamine being requested for acute treatment of toxoplasmosis? If YES, go to 4, if NO go to 5.

☐ Yes ☐ No

Q4. Does the patient have severe or prolonged symptoms that warrants treatment?

☐ Yes ☐ No

Q5. Does the patient have a confirmed diagnosis of HIV? If YES, go to 6.

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q6. Is pyrimethamine being requested for primary prophylaxis of toxoplasmosis gondii (T. gondii) infection? If YES, go to 7. If NO, go to 9.

☐ Yes ☐ No

Q7. Does the patient have documentation of a CD4 count less than 100 cells/mm*3? If YES, go to 8.

☐ Yes ☐ No

Q8. Is the patient T. gondii IgG positive?

☐ Yes ☐ No

Q9. Is pyrimethamine being requested for secondary prophylaxis of toxoplasmosis gondii infection? If YES, go to 11. If NO, go to 10.

☐ Yes ☐ No

Q10. Is pyrimethamine being requested for primary prophylaxis of Pneumocystis jirovecii pneumonia? If YES, go to 11. If NO, go to 12.

☐ Yes ☐ No

Q11. Does the patient have CD4 count less than 200 cells/mm*3?

☐ Yes ☐ No

Q12. Is pyrimethamine being requested for treatment of cystoisosporiasis? If NO, go to 13.

☐ Yes ☐ No

Q13. Is pyrimethamine being requested for secondary prophylaxis of cystoisosporiasis? If YES, got to 14.

☐ Yes ☐ No

Q14. Does the patient have CD4 count less than 200 cells/mm*3 within the past 6 months?

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q15. Requested Duration:

☐ 12 Months ☐ Other

Q16. Additional Information:

_____ _____

Prescriber Signature Date

v2026