Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Pyrimethamine

Fax back to: (833) 605-4407
Phone: (215) 991-4300

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.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	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 the 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 the requested drug being prescribed for the treatment of congenital toxoplasmosis in a pediatric patient in combination with sulfadiazine and leucovorin?

☐ Yes ☐ No

Q2. Is the requested drug being prescribed for the treatment of toxoplasmosis?

☐ Yes ☐ No

Q3. Is the requested drug being prescribed for secondary prophylaxis of toxoplasmosis?

☐ Yes ☐ No

Q4. Does the patient have a CD4 cell count of less than 200 cells/mm3 within the past 3 months?

☐ Yes ☐ No

Q5. Is the requested drug being prescribed for any of the following: A) primary prophylaxis of toxoplasmosis, B) Pneumocystis jirovecii pneumonia prophylaxis?

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q6. Is the requested drug being prescribed for the treatment of cystoisosporiasis in patients unable to use sulfa agents?

☐ Yes ☐ No

Q7. Is the requested drug being prescribed for secondary prophylaxis of cystoisosporiasis?

☐ Yes ☐ No

Q8. Does the patient have a CD4 cell count of less than 200 cells/mm3 within the past 6 months?

☐ Yes ☐ No

Q9. Additional Information:

_____ _____

Prescriber Signature Date

v2025