Clinical Policy: Pyrimethamine (Daraprim)
Reference Number: HIM.PA.133
Effective Date: 01.01.18
Last Review Date:
Line of Business: Health Insurance Marketplace

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Pyrimethamine (Daraprim®) is a folic acid antagonist.

FDA Approved Indication(s)
Daraprim is indicated for the treatment of toxoplasmosis when used conjointly with a sulfonamide.

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria

I. Initial Approval Criteria
A. Initial Therapy for Toxoplasmosis Infection – Active Disease (must meet all):
   1. Diagnosis of toxoplasmosis;
   2. Prescribed by or in consultation with an infectious disease specialist;
   3. Member meets one of the following (a or b):
      a. Age < 18 years;
      b. Failure of ≥ 10 days, or radiological deterioration within 7 days, of trimethoprim/sulfamethoxazole (TMP/SMX) at maximum indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
   4. Daraprim is prescribed with sulfadiazine or clindamycin, and leucovorin;
   5. Doses do not exceed (a or b):
      a. Immunocompromised member: initial loading dose of 200 mg, followed by ≤ 75 mg per day for treatment duration;
      b. Immunocompetent member: initial loading dose of 100 mg, followed by ≤ 50 mg per day for treatment duration.

Approval duration: Duration of request or 8 weeks (whichever is less)

B. Primary Prophylaxis for Toxoplasmosis – Preventing 1st Episode (off-label) (must meet all):
   1. Diagnosis of HIV infection and both of the following (a and b):
      a. CD4 counts < 100 cells/mm³;
      b. Seropositive for Toxoplasma gondii IgG;
   2. Prescribed by or in consultation with an infectious disease specialist;
   3. Request is for prevention for toxoplasmosis;
   4. Member is contraindicated or has clinically significant adverse effects to TMP/SMX;
5. Daraprim is prescribed with leucovorin and dapsone;
6. Dose does not exceed 75 mg per week.

Approval duration: 6 months

C. Other diagnoses/indications
1. Refer to HIM.PHAR.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy
A. Chronic Maintenance – Following Initial Therapy for Active Disease (off-label) (must meet all):
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is HIV-infected with CD4 counts ≤ 200 cells/mm³ at any time in the previous 6 months;
3. Adherence to antiretroviral therapy as evidenced by pharmacy claims history or office notes;
4. Daraprim is prescribed with sulfadiazine or clindamycin, and leucovorin;
5. Dose does not exceed 50 mg per day.

Approval duration: 6 months

B. Primary Prophylaxis for Toxoplasmosis – Preventing 1st Episode (off-label) (must meet all):
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is HIV-infected with CD4 counts ≤ 200 cells/mm³ at any time in the previous 3 months;
3. Adherence to antiretroviral therapy as evidenced by pharmacy claims history or office notes;
4. Daraprim is prescribed with leucovorin and dapsone;
5. Dose does not exceed 75 mg per week.

Approval duration: 3 months

C. Other diagnoses/indications (must meet 1 or 2):
1. Currently receiving medication via health plan benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to HIM.PA.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:
A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – HIM.PHAR.21 or evidence of coverage documents;
B. Malaria.
IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CDC: Centers for Disease Control and Prevention
FDA: Food and Drug Administration
HHS: Department of Health and Human Services
HIV: human immunodeficiency virus
TMP/SMX: trimethoprim/sulfamethoxazole

Appendix B: Use in Malaria

On June 21, 2017, Daraprim’s FDA labeling was updated to exclude the previously approved indications for treatment and chemoprophylaxis of malaria. These uses are not recommended per the CDC malaria treatment guidelines due to prevalent worldwide resistance to pyrimethamine.

V. References


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<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
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Clinical Policy
Pyrimethamine

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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