

pyrimethamine (Daraprim[®], generic)

Policy # 00530

Original Effective Date: 01/01/2017

Current Effective Date: 08/01/2026

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Investigational or experimental services are not covered. This includes any drug, device, procedure, or service provided under the investigational arm of a clinical trial or clinical study. These services are excluded from coverage under benefits.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider pyrimethamine (Daraprim[®], generic)[‡] for various infectious conditions to be **eligible for coverage**.^{**}

Patient Selection Criteria

Coverage eligibility for pyrimethamine (Daraprim, generic) will be considered when the following criteria are met:

- For Daraprim brand requests: Patient has tried and failed (e.g. intolerance or inadequate response) the generic equivalent pyrimethamine unless there is clinical evidence or patient history that suggests the generic equivalent will be ineffective or cause an adverse reaction to the patient; AND
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*
- Patient meets any of the following diagnoses AND their subsequent requirements (if any):
 - Daraprim or its generic is being used for the treatment of toxoplasmosis[∞]; AND
 - Patient is using Daraprim or its generic in combination with a sulfonamide unless contraindicated, not tolerated, or has been tried and had an inadequate response; OR
 - Daraprim or its generic is being used for the prevention of an initial episode of toxoplasmosis in HIV infected patients (AHFS); AND
 - Patient has an intolerance or contraindication to trimethoprim-sulfamethoxazole (CDC/NIH/IDSA); OR
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*

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- Daraprim or its generic is being used to prevent a recurrence of toxoplasmosis in HIV infected patients (AHFS); OR
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*
- Daraprim or its generic is being used to treat or prevent a recurrence of cystoisosporiasis in HIV infected patients (AHFS); AND
 - Patient has an intolerance or contraindication to trimethoprim-sulfamethoxazole (CDC/NIH/IDSA); OR
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*
- Daraprim or its generic is being used to prevent an initial episode or recurrence of *Pneumocystis jiroveci* pneumonia in HIV infected patients (AHFS); AND
 - Patient has an intolerance or contraindication to trimethoprim-sulfamethoxazole (CDC/NIH/IDSA).
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*

Abbreviations: NIH=National Institutes of Health, CDC=Centers for Disease Control and Prevention, IDSA=Infectious Diseases Society of America, AHFS=American Hospital Formulary Services, HIV=Human Immunodeficiency Virus

[°]FDA Approved

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of pyrimethamine (Daraprim, generic) WITHOUT meeting the criteria denoted in the above section as **not medically necessary**** (e.g. trial, intolerance, contraindications of previous drugs, etc.) to be **not medically necessary.****

Based on review of available data, the Company considers the use of brand Daraprim without a trial and failure of generic pyrimethamine to be **not medically necessary.****

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers the use of pyrimethamine (Daraprim, generic) for any indication other than its respective FDA approved indication (except those allowed in the patient selection criteria above) to be **investigational.***

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Background/Overview

Daraprim is a drug that has been around for quite some time. In 2017, it garnered press due to the pricing practices of Turing Pharmaceuticals. Daraprim was originally FDA-approved for the treatment of toxoplasmosis, the treatment of acute malaria, and the chemoprophylaxis of malaria. In August 2017, the indications for the treatment of acute malaria and for chemoprophylaxis of malaria were removed from the label. In 2020, a generic formulation of Daraprim became available and, like the brand product, is currently only indicated for the treatment of toxoplasmosis when used conjointly with a sulfonamide, since synergism exists with this combination. Due to widespread resistance and availability of faster acting agents, use of pyrimethamine for both the treatment and prophylaxis of malaria is no longer recommended by the CDC. Pyrimethamine is a folic acid antagonist and can cause dose-related suppression of the bone marrow; therefore, leucovorin, a folinic acid, should be prescribed in conjunction with pyrimethamine to protect the bone marrow from the toxic effects of pyrimethamine. Other organizations such as the Infectious Diseases Society of America, the Centers for Disease Control and Prevention, the National Institutes of Health, and the American Hospital Formulary Services have formulated recommendations for appropriate off-label uses for Daraprim as well as recommended therapies for certain conditions in which Daraprim is approved (or recommended off-label to treat). Those uses are noted in the patient selection criteria and are denoted by the organization's initials for which the recommendation originated.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Daraprim was originally approved in early 1953 for the treatment of toxoplasmosis, the treatment of acute malaria, and the chemoprophylaxis of malaria. In August 2017, the indication was reduced to the treatment of toxoplasmosis when used conjointly with a sulfonamide, since synergism exists with this combination. As of early 2020, there is generic availability of pyrimethamine.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

The rationale behind this policy is to ensure that Daraprim and its generic are being appropriately utilized based on FDA approvals and guideline recommendations. This policy also ensures that the generic product is utilized, where possible.

References

1. Daraprim [package insert]. Turing Pharmaceuticals. New York, New York. Updated June 2017.
2. Centers for Disease Control and Prevention. www.cdc.gov.
3. National Institutes of Health. www.NIH.gov
4. Infectious Diseases Society of America. www.idsociety.org
5. American Hospital Formulary Service. www.ahfsdruginformation.com.

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6. Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. National Institutes of Health, Centers for Disease Control and Prevention, HIV Medicine Association, and Infectious Diseases Society of America September 2024. Available at <https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection>. Accessed June 11, 2025.
7. Centers for Disease Control and Prevention – Toxoplasmosis. Available at: <https://www.cdc.gov/parasites/toxoplasmosis/index.html>. Accessed on June 11, 2025.
8. Centers for Disease Control and Prevention – Clinical Guidance: Malaria Diagnosis and Treatment in the U.S. Available at: <https://www.cdc.gov/malaria/hcp/clinical-guidance/index.html>. Accessed on June 17, 2025.
9. Pyrimethamine: Drug information. *UpToDate*. Retrieved June 17, 2025, from www.uptodate.com/contents/pyrimethamine-druginformation?source=auto_suggest&selectedTitle=1~1---1~4---pyrime&search=pyrimethamine.

Policy History

Original Effective Date: 01/01/2017

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09/08/2016	Medical Policy Committee review
09/21/2016	Medical Policy Implementation Committee approval. New policy.
09/07/2017	Medical Policy Committee review
09/20/2017	Medical Policy Implementation Committee approval. No change to coverage.
09/06/2018	Medical Policy Committee review
09/19/2018	Medical Policy Implementation Committee approval. No change to coverage.
09/05/2019	Medical Policy Committee review
09/11/2019	Medical Policy Implementation Committee approval. No change to coverage.
07/02/2020	Medical Policy Committee review
07/08/2020	Medical Policy Implementation Committee approval. Added the newly available generic pyrimethamine to the policy. Added “generic” to the title. Also, updated to require use of the generic pyrimethamine first.
07/01/2021	Medical Policy Committee review
07/14/2021	Medical Policy Implementation Committee approval. No change to coverage.
07/07/2022	Medical Policy Committee review
07/13/2022	Medical Policy Implementation Committee approval. No change to coverage.
07/06/2023	Medical Policy Committee review
07/12/2023	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
07/02/2024	Medical Policy Committee review
07/10/2024	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
07/03/2025	Medical Policy Committee review
07/09/2025	Medical Policy Implementation Committee approval. Removed coverage criteria for use in the treatment of acute malaria and for prophylaxis of malaria. Updated background information and references.

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07/21/2026 Pre Pharmacy & Therapeutics Committee review.

07/22/2026 Pharmacy & Therapeutics Committee approval. Coverage eligibility unchanged.

Next Scheduled Review Date: 07/2027

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
 1. Consultation with technology evaluation center(s);
 2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
 3. Reference to federal regulations.

**Medically Necessary (or “Medical Necessity”) - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient’s health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

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NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

NOTICE: If an authorization for an ongoing course of treatment has been provided to a member and the member changes from one health plan to another health plan (e.g., a member moves from carrier A to Louisiana Blue), Louisiana Blue may honor the previous health plan's authorization for the same service under the same type of in-network benefit for a 90-day transition period. Documentation of the authorization for the ongoing course of treatment from the previous health plan must be provided to us by the member or their provider and the services provided for the course of treatment must otherwise be a covered service under the Louisiana Blue health plan. This provision does not apply to medications covered under the plan's pharmacy benefit.