

# OPTIMA FAMILY CARE MEDALLION 4.0

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST\*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.

**Drug Requested:**                      **Sirturo™** (bedaquiline)

**DRUG INFORMATION:** Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

Approval with a quantity limit of **68 tablets for the first 28 days** of treatment and then followed by **24 tablets per 28 days for the next 20 weeks.**

**CLINICAL CRITERIA:** Check below ALL that apply. Boxes must be checked to qualify or authorization process will be delayed. Chart notes and lab results MUST be attached to this request.

Patient is at least ≥ 18 years old **AND** enrolled in a DOT (*Directly Observed Therapy*) Program

**AND**

Diagnosis of Pulmonary Multi-Drug Resistant Tuberculosis (MDR-TB)  
*(Please send Sputum culture for mycobacterium. Cultures provide precise species identification, drug sensitivity testing, and genotyping for epidemiologic purposes.)*

**OR**

Charts/Labs must be provided to document an M. tuberculosis isolate that is resistant to at least isoniazid, rifampin, and possibly additional agents

**AND**

Does the patient have diagnosis of latent or extra-pulmonary tuberculosis?                       YES    **OR**     NO  
*(Not indicated for treatment of latent, extra-pulmonary or drug sensitive TB)*

**AND**

Sirturo™ to be used in combination with three other drugs?                       YES    **OR**     NO  
 *Please mark all agents member is using in combination with Sirturo™: (at least 3 must be marked)*

<input type="checkbox"/> Rifampicin	<input type="checkbox"/> Dapsone	<input type="checkbox"/> Amikacin	<input type="checkbox"/> Capreomycin	<input type="checkbox"/> Kanamycin
<input type="checkbox"/> Cycloserine	<input type="checkbox"/> Ethambutol	<input type="checkbox"/> Ethionamide	<input type="checkbox"/> Clofazimine	<input type="checkbox"/> Pyrazinamide
<input type="checkbox"/> 4-Aminosalicylic acid	<input type="checkbox"/> Isoniazid	<input type="checkbox"/> Linezolid	<input type="checkbox"/> Terizidone	<input type="checkbox"/> Ofloxacin
<input type="checkbox"/> Streptomycin				

**\*\*Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.\*\***

**\*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.\***

Patient Name: \_\_\_\_\_

Member Optima #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

DEA OR NPI #: \_\_\_\_\_