OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 or 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 to ensure authorization will **NOT** 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 drugs the member is using in combination with Sirturo™: (at least 3 must be marked)**

(Continued on next page; signature page MUST be included with this request.)

Antibiotic Drugs (check each that the member is using in combination with Sirturo™; at least **three (3) must** be marked.)				
❑ Rifampicin	❑ Dapsone	❑ Amikacin	❑ Capreomycin	❑ Kanamycin
❑ Cycloserine	❑ Ethambutol	❑ Ethionamide	❑ Clofazimine	❑ Pyrazinamide
❑ 4-Aminosalicylic acid	❑ Isoniazid	❑ Linezolid	❑ Terizidone	❑ Ofloxacin
❑ 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 #: _____

***REVISED/UPDATED:** ~~8/27/2017;~~ **8/30/2018**