OPTIMA HEALTH PLAN

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. Authorization process will be delayed if incomplete.***

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 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)***

❑ 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 #: _____

***Approved by Pharmacy and Therapeutics Committee:** 2/20/2014
REVISED/UPDATED: ~~3/5/2014; 4/4/2014; 5/6/2014; 5/28/2014; 6/10/2014; 11/5/2014; 5/22/2015; 12/19/2016;~~ **9/23/2017**