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 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*)**

❑ 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;~~ **8/17/2017**