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. **If information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Sirturo® (bedaquiline)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Quantity Limit: 68 tablets for the first 28 days of treatment and then **24 tablets per 28 days for the next 20 weeks**.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member is ≥ 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

AND

(Continued on next page)

❑ Please mark all drugs the member is using in combination with Sirturo®: **(at least 3 must be marked)**

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

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****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**: 10/15/2015
REVISED/UPDATED: ~~8/27/2017; 8/30/2018; (Reformatted) 4/1/2021; 6/14/2021;~~ **8/12/2022**