SENTARA HEALTH PLANS

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 the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Sirturo® (bedaquiline)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight (if applicable): _____ **Date weight obtained:** _____

Quantity Limit: 6-month supply for one course of treatment

- 100 mg tablets – 188 tablets per 168 days
- 20 mg tablets – 940 tablets per 168 days

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.

Length of Authorization: 6 months

- ❑ Member is 2 years of age or older and weighs at least 8 kg
- ❑ Member is enrolled in a DOT **(Directly Observed Therapy)** Program
- ❑ Medication is prescribed by or in consultation with an infectious disease specialist

(Continued on next page)

- ❑ Member must meet **ONE** of the following:
  - ❑ Member has a diagnosis of Pulmonary Multi-Drug Resistant Tuberculosis (MDR-TB) **(Submit sputum culture for mycobacterium. Cultures provide precise species identification, drug sensitivity testing, and genotyping for epidemiologic purposes.)**
  - ❑ Provider must submit chart notes and/or lab cultures to document a Mycobacterium tuberculosis isolate that is resistant to at least isoniazid, rifampin, and possibly additional agents
- ❑ Member does **NOT** have a diagnosis of latent or extra-pulmonary tuberculosis **(NOTE: Sirturo® is not indicated for treatment of latent, extra-pulmonary or drug sensitive TB)**
- ❑ Member is taking pretomanid, linezolid and/or moxifloxacin in combination with Sirturo® **(verified by pharmacy paid claims)**

*****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.****

***Approved by Pharmacy and Therapeutics Committee**: ~~10/15/2015; 1/23/2025; 5/22/2025;~~ **9/25/2025**
REVISED/UPDATED/REFORMATTED: ~~8/27/2017; 8/30/2018; 4/1/2021; 6/14/2021;08/12/2022; 10/30/2023; 2/14/2025; 6/4/2025;~~ **10/23/2025**