SENTARA COMMUNITY PLAN
(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. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Pretomanid

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:** _____

Recommended Dosing: 200 mg once daily in combination with bedaquiline and linezolid for 26 weeks

Quantity Limit: 1 tablet per day

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: 26 weeks

- ❑ Member is ≥ 17 years of age
- ❑ Provider is an infectious disease specialist or a pulmonologist
- ❑ Member has a diagnosis of pulmonary extensively drug resistant (XDR), or treatment-intolerant, or nonresponsive multidrug-resistant tuberculosis, **NOT** due to latent or extra-pulmonary infection due to Mycobacterium tuberculosis **(submit chart note notes to include medical history and molecular/phenotypic diagnostics for detection of drug resistance)**

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- ❑ Member had a chest x-ray consistent with pulmonary tuberculosis **(submit documentation)**
- ❑ Member's condition has been non-responsive to isoniazid, rifamycins (such as rifampin), pyrazinamide, ethambutol, a fluoroquinolone (such as levofloxacin) **AND** an injectable (such as amikacin) **(submit pertinent medication history and medical chart notes)**
- ❑ Member must meet **ONE** of the following **(submit documentation)**:
  - ❑ Member has been non-responsive to the best available regimen for at least 6 months
  - ❑ Member is intolerant or a contraindication with any of the following: para-amino salicylic acid, ethionamide, aminoglycosides (such as amikacin), or fluoroquinolones (such as levofloxacin)
- ❑ Pretomanid will be taken in combination with bedaquiline (Sirturo®) and linezolid (Zyvox®) as part of the recommended dosing regimen, and will be administered by directly observed therapy (DOT)
- ❑ Prior to initiating combination therapy, the provider will monitor pertinent laboratory measures and assess for signs of liver injury, myelosuppression, and QT prolongation

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.****

***Approved by Pharmacy and Therapeutics Committee**: ~~4/16/2020;~~ **1/23/2025**
REVISED/UPDATED/REFORMATTED: ~~6/11/2020; 11/13/2023;~~ **2/18/2025**