AvMed

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 1-305-671-0200**. 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 AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

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

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

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

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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

- ❑ 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.****