

# 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:** Pretomanid

**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: \_\_\_\_\_

**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.

**Initial Authorization:** 26 weeks

- The provider is an infectious disease specialist or a pulmonologist

**AND**

- The patient 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 (**Please submit chart note notes to include medical history and molecular/phenotypic diagnostics for detection of drug resistance**)

**AND**

- The patient had a chest x-ray consistent with pulmonary tuberculosis (**Please submit medical chart note**

**AND**

(Continued on next page)

- ❑ The patient'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) (**Please submit pertinent medication history and medical chart notes**)

**AND**

- ❑ The patient been non-responsive to the best available regimen for at least 6 months

**OR**

- ❑ The patient is intolerant or a contraindication with any of the following: para-amino salicylic acid, ethionamide, aminoglycosides (such as amikacin), or fluoroquinolones (such as levofloxacin)

**AND**

- ❑ 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)

**AND**

- ❑ Prior to initiating combination therapy, the provider will monitor pertinent laboratory measures and assess for signs of liver injury, myelosuppression, and QT prolongation

**Reauthorization Approval: 26 Additional Weeks.** 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.

- ❑ The patient's infection of Mycobacterium tuberculosis requires further treatment (i.e. culture negative status was not observed at 6 months) (**Please submit medical chart notes, culture results after initial 6 months treatment**)

**AND**

- ❑ Pretomanid will be taken in combination with bedaquiline (Sirturo®) and linezolid (Zyvox®) as part of the recommended dosing regimen - unless linezolid was discontinued after the first 4 weeks of consecutive treatment, then bedaquiline and pretomanid must be continued concomitantly

**AND**

- ❑ The provider will continue to monitor pertinent laboratory measures and assess for signs of liver injury, myelosuppression, and QT prolongation

**Medication being provided by Specialty Pharmacy - PropriumRx**

*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.\****