UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Pretomanid

Program	Prior Authorization
Medication	Pretomanid
Markets in Scope	Arizona, California, Hawaii, Maryland, Nevada, New Jersey, New York, New York EPP, Pennsylvania –CHIP, Rhode Island, South Carolina
Issue Date	4/2020
Pharmacy and Therapeutics Approval Date	4/2020
Effective Date	6/2020

1. Background:

Pretomanid is an antimycobacterial indicated, as part of a combination regimen with Sirturo (bedaquiline) and Zyvox (linezolid) for the treatment of adults with pulmonary extensively drug resistant (XDR), treatment-intolerant or nonresponsive multidrug-resistant (MDR) tuberculosis (TB).

2. Coverage Criteria:

A. <u>Tuberculosis</u>

1. **Pretomanid** will be approved based on both of the following criteria:

   a. Diagnosis of pulmonary extensively drug resistant (XDR), treatment-intolerant or nonresponsive multidrug-resistant (MDR) tuberculosis (TB)

   -AND-

   b. Pretomanid will be used in combination with bedaquiline and linezolid

Authorization will be issued for one year.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

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4. References:

1. Pretomanid prescribing information. Mylan Specialty L.P., Morgantown, WV. September 2019.

Program	Prior Authorization – Pretomanid
Change Control	
Date	Change
April 2020	New program.

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