

Effective Date: 11/1/07

CRITERIA FOR PRIOR AUTHORIZATION

PROVIDER GROUP: Pharmacy

MANUAL GUIDELINES: The following drug(s) requires prior authorization:
telithromycin (Ketek®)

CRITERIA:

Must meet the following:

1 a.) Patient is continuing a course of therapy initiated while an inpatient at a hospital and must be 18 years of age or older.

OR

b.) Must be at least 18 years old with diagnosis of mild to moderate community acquired pneumonia (CAP) caused by susceptible strains of Streptococcus pneumoniae, Haemophilus influenzae, Moraxella catarrhalis, Chlamydomphila pneumoniae, or Mycoplamsa pneumoniae.

AND

- 2) Provide copy of chest x-ray report.
- 3) Treatment will not be approved if patient has a diagnosis of myasthenia gravis.
- 4) Prior authorizations may be approved for 10 day treatment duration with one renewal. Additional renewals must be approved by the pharmacy program manager.

Warnings: hepatotoxicity, visual disturbances, and loss of consciousness.

Drug Utilization Review Committee Director

Date

9/12/07

Pharmacy Program Manager,
Kansas Health Policy Authority

Date

9/12/07