Initial Approval: May 1997
Revised Date: July 10, 2013
March 2006
November 23, 2005

CRITERIA FOR PRIOR AUTHORIZATION

Tuberculosis Treatments

PROVIDER GROUP Pharmacy

MANUAL GUIDELINES The following drug requires prior authorization:
Aminosalicylate Sodium
Aminosalicylic Acid (Paser Granules®)
Bedaquiline (Sirturo®)
Capreomycin (Capstat®)
Cycloserine (Seromycin®)
Ethambutol (Myambutol®)
Ethionamide (Trecator®)
Isoniazid (Niazid®, Nydrazid®)
Isoniazid/Pyridoxine (Niazid-B6®)
Pyrazinamide
Rifabutin (Mycobutin®)
Rifampin (Rifadin®, Rimactane®)
Rifampin/Isoniazid (Isonarif®, Rifamate®)
Rifampin/Isoniazid/Pyrazinamide (Rifater®)
Rifapentine (Priftin®)

CRITERIA FOR TUBERCULOSIS AGENTS Must meet all of the following:

- Patient must not have a diagnosis of *Mycobacterium tuberculosis*
- All prescriptions written for indications other than *Mycobacterium tuberculosis* will be authorized for the length of time requested by the prescriber

NOTE: Medications for the treatment of TB can be obtained from the Department of Health and Environment

Revision History	
Revision Date	**Revision**
July 10, 2013	Add list of all agents included in prior authorization criteria, including new agent, Sirturo
May 1997	Initial prior authorization criteria approved