PRIOR AUTHORIZATION POLICY

POLICY: Infectious Disease – Sirturo Prior Authorization Policy
- Sirturo® (bedaquiline fumarate tablets – Janssen)

REVIEW DATE: 07/16/2025

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Sirturo, a diarylquinolone antimycobacterial, is indicated as part of a combination therapy in the treatment of **pulmonary tuberculosis (TB)** due to *Mycobacterium tuberculosis* resistant to at least rifampin and isoniazid in patients ≥ 5 years of age (weighing ≥ 15 kg).[1] Reserve Sirturo for use when an effective treatment regimen cannot otherwise be provided.

Limitations of use: Sirturo should not be used for the treatment of latent infections due to *Mycobacterium tuberculosis*, drug-sensitive TB, extra-pulmonary TB, and infections caused by non-tuberculous mycobacteria.

The prescribing information notes the total duration of treatment with Sirturo to be 24 weeks (adults and pediatric patients).[1]

Guidelines

The World Health Organization issued an operational handbook (2023) with information on the choice and design of regimens for the treatment of drug-resistant TB, including multidrug- or rifampin-resistant TB and confirmed rifampicin-susceptible, isoniazid-resistant TB.[2] Drug susceptibility tests are recommended to assist the prescriber in choosing the appropriate initial regimen. In addition, a surveillance system is recommended to determine the local prevalence of drug-resistant TB strains. There are different regimens that include Sirturo and other drugs (e.g., rifampicin, ethambutol, levofloxacin/moxifloxacin, pretomanid, linezolid, clofazimine).

On December 31, 2024 the American Thoracic Society, the Centers for Disease Control and Prevention, the European Respiratory Society, and the Infectious Disease Society of America published an official practice guideline for the treatment of drug-susceptible and drug-resistant tuberculosis in which they recommended a 6-month treatment duration as opposed to previously recommended longer durations (up to 15 months).[4]

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Sirturo. All approvals are provided for the duration noted below. In cases where approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Sirturo as well as the monitoring required for adverse events and long-term efficacy, approval requires Sirturo to be prescribed by or in consultation with a physician who specializes in the condition being treated.

- **Sirturo® (bedaquiline fumarate tablets – Janssen)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

1. **Tuberculosis.** Approve for 6 months if the patient meets ALL of the following (A, B, C, D, and E):
   - **A)** Patient is ≥ 5 years of age; AND
   - **B)** Patient weighs ≥ 15 kg; AND
   - **C)** Patient has *Mycobacterium tuberculosis* resistant to rifampin and isoniazid; AND
   - **D)** Sirturo is prescribed as part of a combination regimen with other anti-tuberculosis agents; AND
   - **E)** The medication is prescribed by or in consultation with an infectious diseases specialist.

CONDITIONS NOT COVERED

- **Sirturo® (bedaquiline fumarate tablets – Janssen)**

is(are) considered not medically necessary for ANY other uses; criteria will be updated as new published data are available.

REFERENCES

1. Sirturo® tablets [prescribing information]. Titusville, NJ: Janssen; June 2024.
2. World Health Organization – Global Tuberculosis Report. 2023. Available at: https://iris.who.int/bitstream/handle/10665/373828/9789240083851-eng.pdf?sequence=1. . Accessed on July 8, 2025.
3. World Health Organization consolidated guidelines on tuberculosis. Module 4: Treatment - drug-resistant tuberculosis treatment. Geneva: World Health Organization. 2022. Available at: https://iris.who.int/bitstream/handle/10665/365308/9789240063129-eng.pdf?sequence=1. Accessed on July 8, 2025.
4. Saukkonen JJ, Duarte R, Munsiff SS, et al. Updates on the treatment of drug-susceptible and drug-resistant tuberculosis: an official ATS/CDC/ERA/IDSA clinical practice guideline. *Am J Respir Crit Care Med*. 2025;211(1):15-33.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	12/06/2023
Early Annual Revision	**Tuberculosis:** The criterion, "Patient has multidrug-resistant tuberculosis" was changed to "Patient has *Mycobacterium tuberculosis* resistant to rifampin and isoniazid." Sirturo received traditional approval from the FDA. The indication for use was changed from "Sirturo is indicated as part of a combination therapy in the treatment of pulmonary multidrug-resistant tuberculosis (TB) in patients ≥ 5 years of age (weighing ≥ 15 kg)" to "Situro is indicated as part of a combination therapy in the treatment of pulmonary tuberculosis (TB) due to *Mycobacterium tuberculosis* resistant to at least rifampin and isoniazidin patients ≥ 5 years of age (weighing ≥ 15 kg)." The limitation "The safety and efficacy of Sirturo in the treatment of patients infected with human immunodeficiency virus (HIV) with multidrug-resistant TB have not been established as clinical data are limited" has been removed from the policy.	07/03/2024
Annual Revision	**Tuberculosis.** The approved duration for this condition was changed to 6 months. Previously, it was 9 months.	07/16/2025