Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Sirturo

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Does the patient have a documented diagnosis of pulmonary multi-drug resistant tuberculosis (MDR-TB)?

☐ Yes ☐ No

Q2. Is the patient 5 years of age or older?

☐ Yes ☐ No

Q3. Is there documentation that Sirturo is being used in combination with at least 3 other medications to which the patient's MDR-TB isolate has been shown to be susceptible in vitro?

☐ Yes ☐ No

Q4. Are in vitro testing results unavailable and Sirturo is being used in combination with at least 4 other medications to which the patient's MDR-TB isolate is likely to be susceptible?

☐ Yes ☐ No

Q5. Is Sirturo being prescribed by or in consultation with an infectious disease specialist?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q6. Additional Information:	

Prescriber Signature _____ Date _____

v2025