



**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.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: <input type="checkbox"/> Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	<b>Specialty/facility name (if applicable):</b>

**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.**

<p>Q1. Does the patient have a documented diagnosis of pulmonary tuberculosis pulmonary?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Is there documentation of resistance to rifampin and isoniazid?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Is the patient 2 years of age or older, weight at least 8 kg?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Is there documentation that Sirturo is being used in combination with at least 2 other anti-tuberculosis agents?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Is Sirturo being prescribed by or in consultation with an infectious disease specialist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



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**Patient Name:**

**Prescriber Name:**

Q6. Additional Information:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2026