Pharmacy Medical Necessity Guidelines: Priftin (rifapentine)

Effective: February 9, 2021

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM

These pharmacy medical necessity guidelines apply to the following:

Commercial Products

☐ Tufts Health Plan Commercial products – large group plans
☐ Tufts Health Plan Commercial products – small group and individual plans
☐ Tufts Health Freedom Plan products – large group plans
☐ Tufts Health Freedom Plan products – small group plans
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Tufts Health Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:
RXUM: 617.673.0988

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Priftin (rifapentine) is a rifamycin derivative approved for the treatment of active tuberculosis (TB) caused by *Mycobacterium tuberculosis* in patients 12 years of age and older in combination with one or more anti-TB drugs to which the isolate is susceptible. Priftin is also approved for the treatment of latent tuberculosis infection (LTBI) caused by *M. tuberculosis* in combination with isoniazid in patients 2 years of age and older at a high risk of progression to TB disease.

COVERAGE GUIDELINES

The plan may authorize coverage of Priftin (rifapentin) for Members when the following criteria are met:

1. The member has a diagnosis of active pulmonary tuberculosis

AND

The member is 12 years of age or older

AND

Priftin (rifapentine) is being prescribed in combination with one or more anti-tuberculosis drugs (e.g., isoniazid, pyrazinamide, ethambutol)

AND

The Member has tried and failed treatment with, or the provider indicates clinical inappropriateness of treatment with a rifampin-based treatment regimen

OR

2. The member has a diagnosis of latent tuberculosis infection (LTBI)

AND

The member is 2 years of age or older

AND

Priftin (rifapentine) is being prescribed in combination with isoniazid

LIMITATIONS

None

CODES

None

REFERENCES

1. Priftin (rifapentine) [prescribing information]. Bridgewater, NJ: Sanofi-Aventis; June 2020.
2. Nahid P, Dorman SE, Alipanah N, Barry PM, Brozek JL, Cattamanchi A, et al. Official American Thoracic Society/Centers for Disease Control and Prevention/Infectious Diseases Society of America clinical practice guidelines: treatment of drug-susceptible tuberculosis. Clin Infect Dis. 2016;63:e47.

3. Sterling TR. Treatment of drug-susceptible pulmonary tuberculosis in HIV-uninfected patients. Available at www.uptodate.com. Accessed 24 January 2020.
4. Sterling TR, Zenner D, Njie G, et al. Guidelines for the treatment of latent tuberculosis infection: recommendations from the National Tuberculosis Controllers Association and CDC, 2020. *MMWR*. 2020;69:1-11.
5. Borisov AS, Bamrah Morris S, Njie GJ, et al. Update of recommendations for use of once-weekly isoniazid-rifapentin regimen to treat latent *Mycobaceterium tuberculosis* Infection. *MMWR.* 2018;67:723-726. DOI: dx.doi.org/10.15585/mmwr.mm6725a5.

APPROVAL HISTORY

April 10, 2018: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
1. March 12, 2019: Administrative changes made to template.
2. February 11, 2020: No changes.
3. February 9, 2021: No changes.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.