Effective Date 3/15/2025
Coverage Policy Number IP0384

Pretomanid

Table of Contents

Related Coverage Resources

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 and have discretion in making individual coverage determinations. 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.

Overview

This policy supports medical necessity review for pretomanid tablets.

Medical Necessity Criteria

Pretomanid is considered medically necessary when the following are met:

1. **Treatment of Pulmonary Tuberculosis.** Individual meets **ALL** of the following criteria:
    A. Age 18 years or older
    B. Documentation of **ONE** of the following:
        i. Extensively drug resistant tuberculosis
        ii. Treatment-intolerant tuberculosis
        iii. Nonresponsive multidrug-resistant tuberculosis
    C. Pretomanid is prescribed in combination with bedaquiline (Sirturo®) and linezolid (Zyvox®)
    D. Medication is prescribed by, or in consultation with, an infectious diseases specialist

---

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Reauthorization Criteria

Continuation of Pretomanid is considered medically necessary for the treatment of pulmonary tuberculosis when the above medical necessity criteria are met AND there is documentation of beneficial response.

Authorization Duration

Initial approval duration: up to 9 months
Reauthorization approval duration: up to 9 months

Conditions Not Covered

Any other use is considered experimental, investigational or unproven.

Background

OVERVIEW
Pretomanid, a nitroimidazole, is indicated as part of a combination regimen with Sirturo® (bedaquiline tablets) and linezolid tablets or oral suspension (Zyvox®, generic) for the treatment of **pulmonary extensively drug-resistant or treatment-intolerant or nonresponsive multidrug-resistant tuberculosis (TB)** in adults.[1] Approval of this indication is based on limited clinical safety and efficacy data. This drug is indicated for use in a limited and specific population of patients.

Limitation of use: Pretomanid is not indicated for use in patients with the following conditions: drug-sensitive TB, latent infection due to *Mycobacterium tuberculosis*, extra-pulmonary infection due to *M. tuberculosis*, multidrug-resistant TB that is not treatment-intolerant or nonresponsive to standard therapy. The safety and effectiveness of Pretomanid when used with drugs other than Sirturo and linezolid have not been established.

The prescribing information notes the total duration of treatment with Pretomanid, Sirturo, and linezolid to be 26 weeks.[1] The dosing of the combination regimen can be extended beyond 26 weeks.[2]

Guidelines
The World Health Organization (WHO) issued consolidated guidelines (2022) 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. The WHO notes that the duration of treatment is different for regimens containing different drugs. The duration for regimens containing Pretomanid, Sirturo, and linezolid range from 6 to 9 months.

References

1. Pretomanid tablets [prescribing information]. Limited Hyerabad, India: Mylan; November 2024.
2. World Health Organization consolidated guidelines on tuberculosis. Module 4: treatment - drug-resistant tuberculosis treatment, 2022. Geneva: World Health Organization. 2022. Available at: https://www.who.int/publications/i/item/9789240063129. Accessed on December 5, 2024.

Revision Details

Type of Revision	Summary of Changes	Date
Annual Revision	No criteria changes	3/15/2025

The policy effective date is in force until updated or retired.