

Clinical Policy: Bedaquiline (Sirturo)

Reference Number: CP.PMN.212

Effective Date: 09.04.18

Last Review Date: 02.26

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Bedaquiline (Sirturo[®]) is a diarylquinoline antimycobacterial drug.

FDA Approved Indication(s)

Sirturo is indicated as part of combination therapy in the treatment of adult and pediatric patients (2 years and older and weighing at least 8 kg) with pulmonary tuberculosis (TB) due to *Mycobacterium tuberculosis* resistant to at least rifampin and isoniazid.

Limitation(s) of use: Do not use Sirturo for the treatment of:

- Latent infection due to *Mycobacterium tuberculosis*
- Drug-sensitive pulmonary TB
- Extra-pulmonary TB
- Infections caused by non-tuberculous mycobacteria

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Sirturo is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Multi-Drug Resistant Tuberculosis without Pretomanid (must meet all):

1. Diagnosis of multi-drug resistant (MDR)-TB (i.e., resistant to at least rifampin and isoniazid);
2. Prescribed by or in consultation with an infectious disease specialist, pulmonologist, or expert in the treatment of TB (e.g., state or county public health department, specialists affiliated with TB Centers of Excellence as designated by the CDC, infectious disease specialists managing TB clinics);
3. Age \geq 2 years;
4. Weight \geq 8 kg;
5. Prescribed in combination with at least 3 other anti-TB agents (*Appendix B*);
6. Request does not exceed health plan-approved quantity limit, if applicable;
7. Dose does not exceed one of the following (a, b, c, or d):
 - a. Weight \geq 30 kg: 400 mg per day for the first 2 weeks, followed by 200 mg three times per week;

- b. Weight \geq 15 kg to $<$ 30 kg: 200 mg per day for the first 2 weeks, followed by 100 mg three times per week;
- c. Weight \geq 10 kg to $<$ 15 kg: 120 mg per day for the first 2 weeks, followed by 60 mg three times per week;
- d. Weight \geq 8 kg to $<$ 10 kg: 80 mg per day for the first 2 weeks, followed by 40 mg three times per week.

Approval duration: 24 weeks

B. Multi-Drug Resistant Tuberculosis with Pretomanid (must meet all):

1. Diagnosis of pulmonary MDR-TB or extensively drug resistant (XDR)-TB;
2. Prescribed by or in consultation with an expert in the treatment of TB (e.g., state or county public health department, specialists affiliated with TB Centers of Excellence as designated by the CDC, infectious disease specialists managing TB clinics);
3. Age \geq 14 years;
4. Prescribed in combination with pretomanid and linezolid;
**Prior authorization may be required for pretomanid and linezolid.*
5. One of the following (a or b):
 - a. Prescribed in combination with moxifloxacin (off-label);
 - b. Documented resistance to fluoroquinolones, unless contraindicated or clinically significant adverse effects are experienced;
6. Request does not exceed health plan-approved quantity limit, if applicable;
7. Dose does not exceed 400 mg per day for the first 2 weeks, followed by 200 mg three times per week.

Approval duration: 26 weeks

C. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Multi-Drug Resistant Tuberculosis without Pretomanid (must meet all):

1. Member meets one of the following (a or b):

- a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
- b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy;
3. Member has not received more than 24 weeks of Sirturo therapy;
4. Request does not exceed health plan-approved quantity limit, if applicable;
5. If request is for a dose increase, new dose does not exceed one of the following (a, b, c, or d):
 - a. Weight \geq 30 kg: 200 mg three times per week;
 - b. Weight \geq 15 kg to $<$ 30 kg: 100 mg three times per week;
 - c. Weight \geq 10 kg to $<$ 15 kg: 60 mg three times per week;
 - d. Weight \geq 8 kg to $<$ 10 kg: 40 mg three times per week.

Approval duration: up to a total duration of 24 weeks

B. Multi-Drug Resistant Tuberculosis with Pretomanid (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy;
3. Member meets one of the following (a or b):
 - a. Member continues to receive pretomanid and linezolid in combination with Sirturo;
 - b. Member continues to receive pretomanid and has completed at least 4 weeks of linezolid therapy;
4. Member has not received more than 26 weeks of Sirturo therapy;
5. Request does not exceed health plan-approved quantity limit, if applicable;
6. If request is for a dose increase, new dose does not exceed 200 mg three times per week.

Approval duration: up to a total treatment duration of 26 weeks

C. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business:

CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

BPaL: bedaquiline, pretomanid, and linezolid

CDC: Centers for Disease Control

DOT: directly observed therapy

FDA: Food and Drug Administration

MDR-TB: multi-drug resistant tuberculosis

XDR-TB: extensively drug resistant tuberculosis

TB: tuberculosis

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
amikacin/kanamycin	15 mg/kg IM or IV QD or 25 mg/kg PO 3 times weekly	15 mg/kg/day
capreomycin	15 mg/kg IM or IV QD or 25 mg/kg PO 3 times weekly	1,000 mg/day
cycloserine	10 to 15 mg/kg PO QD or BID	1,000 mg/day
ethambutol	Follow weight-based dosing in prescribing information	4,000 mg/dose
ethionamide	10 to 20 mg/kg PO QD or BID	1,000 mg/day
imipenem-cilastatin*	1,000 mg IV BID	2,000 mg/day
levofloxacin	500 to 1,000 mg PO or IV QD	1,000 mg/day
linezolid	600 mg PO or IV QD	600 mg/day
meropenem*	2,000 mg IV BID or TID	6,000 mg/day
moxifloxacin	400 mg PO or IV QD	400 mg/day
para-aminosalicylic acid	8 to 12 g PO BID or TID	12 g/day
pyrazinamide	Follow weight-based dosing in prescribing information	4,000 mg/dose
streptomycin	15 mg/kg IM or IV QD or 25 mg/kg PO 3 times weekly	20 mg/kg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
pretomanid	200 mg PO QD for 26 weeks.	200 mg/day
linezolid	600 - 1,200 mg PO QD	1,200 mg/day

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

*Amoxicillin-clavulanic acid should be coadministered with every dose of imipenem-cilastatin or meropenem but is not counted as a separate agent and should not be used as a separate agent.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s): QT prolongation

Appendix D: General Information

For MDR-TB:

- Sirturo should only be used in combination with at least 3 other drugs to which the patient's MDR-TB isolate has been shown to be susceptible *in vitro*. If *in vitro* testing results are unavailable, Sirturo treatment may be initiated in combination with at least 4 other drugs to which the patient's MDR-TB isolate is likely susceptible.
- Laboratory confirmation of multi-drug resistant TB must show TB with an isolate showing genotypic or phenotypic resistance to isoniazid and rifampin.

For MDR-TB or XDR-TB with pretomanid:

- CDC Centers of Excellence for TB: https://www.cdc.gov/tb/education/tb_coe/default.htm
- Pretomanid should only be used in combination with Sirturo and linezolid.
- Laboratory confirmation of multi-drug resistant TB must show TB with an isolate showing genotypic or phenotypic resistance to isoniazid and rifampin.
- Laboratory confirmation of extensively drug resistant TB must show TB with an isolate showing genotypic or phenotypic resistance to isoniazid, rifampin, fluoroquinolones, as well as second-line injectable agents such as aminoglycosides or capreomycin.
- Linezolid starting dose of 1,200 mg daily for 26 weeks may be managed as follows:
 - Adjusted to 600 mg daily and further reduced to 300 mg daily as necessary for adverse reactions of myelosuppression, peripheral neuropathy, and optic neuropathy.
 - Doses of the regimen missed for safety reasons can be made up at the end of treatment; doses of linezolid alone missed due to adverse reactions should not be made up.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MDR-TB	Weight ≥ 30 kg: 400 mg PO QD for the first 2 weeks, followed by 200 mg PO three times per week (with at least 48 hours between doses) for 22 weeks (total duration of 24 weeks).	Weight ≥ 30 kg: 400 mg/dose
	Weight 15 to < 30 kg: 200 mg PO QD for the first 2 weeks, followed by 100 mg PO three times per week	Weight 15 to 29 kg: 200 mg/dose

Indication	Dosing Regimen	Maximum Dose
	<p>(with at least 48 hours between doses) for 22 weeks (total duration of 24 weeks).</p> <p>Weight 10 to < 15 kg: 120 mg PO QD for the first 2 weeks, followed by 60 mg PO three times per week (with at least 48 hours between doses) for 22 weeks (total duration of 24 weeks).</p> <p>Weight 8 to < 10 kg: 80 mg PO QD for the first 2 weeks, followed by 40 mg PO three times per week (with at least 48 hours between doses) for 22 weeks (total duration of 24 weeks).</p> <p>Sirturo should be administered by directly observed therapy (DOT)</p>	<p>Weight 10 to 14 kg: 120 mg/dose</p> <p>Weight 8 to 9 kg: 80 mg/dose</p>
MDR-TB or XDR-TB with pretomanid	<p>Administer in combination with pretomanid and linezolid (BPaL regimen) in a DOT setting.</p> <ul style="list-style-type: none"> • Sirturo: 400 mg PO QD for the first 2 weeks, followed by 200 mg PO three times per week (with at least 48 hours between doses) for 24 weeks (total duration of 26 weeks*). • Pretomanid: 200 mg PO QD for 26 weeks. • Linezolid: 600 mg PO QD for 26 weeks. <p>Patients 17 years of age or older may continue treatment with Sirturo and pretomanid without linezolid if the patient has previously received a total daily dose of linezolid 1,200 mg for at least 4 weeks.</p>	400 mg/dose

VI. Product Availability

Tablets: 20 mg, 100 mg

VII. References

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6. Pretomanid Prescribing Information. Hyderabad, India: Mylan; November 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/212862s008lbl.pdf. Accessed October 30, 2024.
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15. WHO consolidated guidelines on tuberculosis: Module 4: Treatment and care [Internet]. Geneva: World Health Organization; 2025. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK613092/>. Accessed November 24, 2025. PMID: 40163610.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2022 annual review: no significant changes; references reviewed and updated.	09.23.21	02.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.05.22	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2023 annual review: for use without Pretomanid added requirement for weight \geq 15 kg per prescribing information; for use with Pretomanid lowered age requirement from 17 to 15 years per updated WHO 2022 guidance, added alternative option if there is no documented fluoroquinolone resistance for off-label use when prescribed in combination with moxifloxacin, clarified approval duration from 6 months to 26 weeks; for continued therapy reinforced therapy duration requirements that were previously only referenced in the approval duration; references reviewed and updated.	10.25.22	02.23
1Q 2024 annual review: no significant changes; updated linezolid dosing from 1,200 mg to 600 mg per updated CDC recommendations; references reviewed and updated.	10.20.23	02.24
RT4: updated FDA approved indications to reflect changes from accelerated to full approval per updated prescribing information; removed increased mortality from boxed warnings.	06.27.24	
1Q 2025 annual review: for continuation of therapy added option for up to 9 month approval duration if request is for Sirturo prescribed in combination with linezolid, moxifloxacin, and pyrazinamide per World Health Organization (WHO) updates to the treatment of drug-resistant tuberculosis; references reviewed and updated.	10.22.24	02.25
RT4: updated to include pediatric extension down to 2 years of age and weighing at least 8 kg for MDR-TB without pretomanid per updated prescribing information.	09.17.25	
1Q 2026 annual review: revised age limit for use with pretomanid down to 14 years of age (from 15 years) per IDSA; removed allowance for use up to 9 months as these extended regimens only recommend bedaquiline be used for 24-26 weeks, not the entire extended treatment duration; per template added requirement that “request does not exceed health plan-approved quantity limit, if applicable”; references reviewed and updated.	11.24.25	02.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health

plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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