# Clinical Policy: Rifapentine (Priftin)

Reference Number: AZ.CP.PMN.05
Effective Date: 01.20.2020
Last Review Date: 02.25
Line of Business: Arizona Medicaid (AzCH-CCP) Revision Log

**See Important Reminder at the end of this policy for important regulatory and legal information.**

**Description**
Rifapentine (Priftin®) is a cyclopentyl rifamycin antimycobacterial agent.

**AHCCCS preferred drugs** in this class include: rifampin.

**AHCCCS non-preferred drugs** in this class include: rifabutin, rifapentine.

**FDA Approved Indication(s)**
Priftin is indicated for:

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

Limitation(s) of use:

- Do not use Priftin monotherapy in either the initial or the continuation phases of active antituberculous treatment. Priftin should not be used once-weekly in the continuation phase regimen in combination with isoniazid in HIV-infected patients with active TB because of a higher rate of failure and/or relapse with rifampin-resistant organisms. Priftin has not been studied as part of the initial phase treatment regimen in HIV-infected patients with active pulmonary tuberculosis
- Active tuberculosis disease should be ruled out before initiating treatment for latent tuberculosis infection. Priftin must always be used in combination with isoniazid as a 12-week once-weekly regimen for the treatment of latent tuberculosis infection. Priftin in combination with isoniazid is not recommended for individuals presumed to be exposed to rifamycin- or - isoniazid resistant *M. tuberculosis*.

**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 Arizona Complete Health-Complete Care Plan that Priftin is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria**

**A. Active Pulmonary Tuberculosis Infection** (must meet all)**:**

1. Diagnosis of TB;
2. Age ≥ 12 years;
3. Prescribed by in consultation with an infectious disease specialist, pulmonologist, or expert in the treatment of tuberculosis (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);
4. Prescribed in combination with one or more anti-tuberculosis drugs (e.g., isoniazid, rifampin, pyrazinamide, ethambutol);
5. If request is for the 4 month daily Priftin regimen, prescribed in combination with isoniazid, moxifloxacin, and pyrazinamide (off-label);
6. Failure of 4 week trial of rifampin, unless contraindicated, medically justified, or clinically significant adverse effects are experienced;
7. Member is not pregnant;
8. If member is HIV-positive, both of the following (a and b):
   a. Request is for the 4 month daily Priftin regimen (off-label);
   b. Recent (within the last 30 days) CD4 count ≥ 100 cells/mm3;
9. Dose does not exceed one of the following (a or b):
   a. For 6 month regimen, both of the following (i and ii):
      i. Induction phase of treatment: 600 mg twice weekly for 2 months;
      ii. Continuation phase: 600 mg (4 tablets) once weekly for 4 months;
   b. For 4 month regimen (off-label): 1,200 mg (8 tablets) per day for 119 doses.

**Approval duration: 6 months**

**B. Latent Tuberculosis Infection** (must meet all)**:**

1. Diagnosis of LTBI;
2. Age ≥ 2 years;
3. Member is not pregnant;
4. Failure of 4 week trial of rifampin, unless contraindicated, medically justified, or clinically significant adverse effects are experienced;
5. One of the following (a or b):
   a. Failure of ≥ 6 month trial of isoniazid at maximally indicated doses;
   b. Member has HIV and is prescribed antiretroviral therapy;
6. Prescribed in combination with isoniazid;
7. Dose does not exceed one of the following (a or b):
   a. 900 mg (6 tablets) per week;
   b. For member with HIV, 600 mg (4 tablets) per day for 4 weeks.

**Approval duration: 12 weeks**

**C. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is

NOT authorized): AHCCCS FFS Prior Authorization Guideline- Coverage of Off-Label Non-FDA Approved Indications.

**II. Continued Therapy**

**A. Active Pulmonary Tuberculosis** (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member has not received up to 6 months of therapy;
3. Prescribed in combination with one or more anti-tuberculosis drugs (e.g. isoniazid, rifampin, pyrazinamide, ethambutol);
4. If request is for the 4 month daily Priftin regimen, prescribed in combination with isoniazid, moxifloxacin, and pyrazinamide (off-label);
5. If request is for a dose increase, new dose does not exceed the following:
   a. Induction phase of treatment: 600 mg twice weekly for 2 months;
   b. Continuation phase: 600 mg once weekly for 4 months;
   c. For 4 month regimen (off-label): 1,200 mg (8 tablets) per day for 119 doses.

**Approval duration: Up to 6 months of total treatment**

**B. Latent Tuberculosis Infection** (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member has not yet received 12 weeks of therapy;
3. Prescribed in combination with isoniazid;
4. Dose does not exceed 900 mg weekly (6 tablets/week).

**Approval duration: Up to 12 weeks of total treatment**

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

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   **Approval duration: Duration of request or 12 (6 for specialty) months (whichever is less)**; or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): AHCCCS FFS Prior Authorization Guideline- Coverage of Off-Label Non-FDA Approved Indications.

**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 – AHCCCS FFS Prior Authorization Guideline- Coverage of Off-Label Non-FDA Approved Indications.

## IV. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration
HIV: human immunodeficiency virus
INH: isoniazid
LTBI: latent tuberculosis infection
DOT: directly observed therapy
RIF: rifampin
*M. tuberculosis*: *Mycobacterium 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 |
|---|---|---|
| isoniazid | 5 mg/kg up to 300 mg daily in a single dose or 15 mg/kg up to 900 mg/day, two or three times/week PO or IM | 300 mg/day daily or 900 mg/day for twice weekly therapy |

*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.*

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): history of hypersensitivity of rifamycins
- Boxed warning(s): none reported

## V. Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| Active Pulmonary Tuberculosis | Initial: 600 mg twice weekly for two months as directly observed therapy (DOT), with no less than 72 hours between doses, in combination with other anti- tuberculosis drugs for 2 months<br><br>Continuation: 600 mg once-weekly for 4 months as DOT with isoniazid or another appropriate anti- tuberculosis agent for 4 months | 900 mg/ dose |
| Latent Tuberculosis Infection | In combination with isoniazid once-weekly for 12 weeks as directly observed therapy or self administration | 12 week regimen: 900 mg/day |

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| | Adults and children ≥ 12 years: Priftin (based on weight, see table below) and isoniazid 15 mg/kg (900 mg maximum)<br>Children 2–11 years: Priftin (based on weight, see table below) and isoniazid 25 mg/kg (900 mg maximum)<br><br>HIV, 4 week regimen – weight-based rifapentine in combination with isoniazid 300 mg and pyridoxine 25-50 mg PO QD:<br><35 kg: 300 mg PO QD<br>35-45 kg: 450 mg PO QD<br>>45 kg: 600 mg PO QD | 4 week regimen: 600 mg/day |

| Weight Range | Priftin Dose | Number of Priftin tablets |
|---|---|---|
| 10–14 kg | 300 mg | 2 |
| 14.1–25 kg | 450 mg | 3 |
| 25.1– 32 kg | 600 mg | 4 |
| 32.1–50 kg | 750 mg | 5 |
| > 50 kg | 900 mg | 6 |

## VI. Product Availability

Tablet: 150 mg

## VII. References

1. Priftin Prescribing Information. Bridgewater, NJ: Sanofi-Aventis U.S. LLC; July 2021. Available at: http://products.sanofi.us/. Accessed January 5, 2023.
2. Centers for Disease Control and Prevention. Recommendations for use of isoniazid-rifapentine regimen with direct observation to treat latent mycobacterium tuberculosis infection: United States, 2011.MMWR Morb Mortal Wkly Rep 2011;60(48);1650-1653.
3. Centers for Disease Control and Prevention. Update of recommendations for use of isoniazid-rifapentine regimen to treat latent mycobacterium tuberculosis infection: United States, 2018. MMWR Morb Mortal Wkly Rep 2018; 67(25);723-726.
4. Centers for Disease Control and Prevention. Treatment of tuberculosis, American Thoracic Society, CDC, and Infectious Diseases Society of America. MMWR 2003;52(No. RR-11):1-77.
5. Nahid P, Dorman SE, Alipanah N 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 Oct 1;63(7):e147-95. doi: 10.1093/cid/ciw376. Epub 2016 Aug 10.

6. 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.
7. Sterling TR, Njie G, Zenner D, et al. Guidelines for the Treatment of Latent Tuberculosis Infection: Recommendations from the National Tuberculosis Controllers Association and CDC, 2020. MMWR. February 14, 2020; 69 (1): 1-11.
8. WHO: Latent tuberculosis infection - Updated and consolidated guidelines for programmatic management. 2018. Available at: https://apps.who.int/iris/bitstream/handle/10665/260233/9789241550239-eng.pdf. Accessed January 30, 2024.
9. Carr W, Kurbatova E, Starks A, et al. Interim Guidance: 4-Month Rifapentine-Moxifloxacin Regimen for the Treatment of Drug-Susceptible Pulmonary Tuberculosis — United States, 2022. MMWR February 25, 2022; 71 (8): 285-289.
10. WHO consolidated guidelines on tuberculosis. Module 4: treatment - drug-susceptible tuberculosis treatment, 2022 update. Geneva: World Health Organization; 2022.
11. WHO consolidated guidelines on tuberculosis. Module 5: Management of tuberculosis in children and adolescents, 2022 update. Geneva: World Health Organization; 2022.

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| Policy created. | 01.16 | 02.16 |
| 1Q 2021 annual review: no significant changes; references reviewed and updated. | 01.26.21 | 01.21 |
| Added Care1st logo. Added verbiage to specify that criteria also applies to Care1st. | 5.10.21 | 04.21 |
| 1Q 2022 annual review: for latent TB modified isoniazid trial duration from 9 to 6 months per CDC and WHO treatment guidelines; references reviewed and updated. | 01.07.22 | 02.22 |
| 1Q 2023 annual review: for active pulmonary TB per updated CDC/WHO recommendations added requirements for optional 4 month daily Priftin regimen prescribed in combination with isoniazid, moxifloxacin, and pyrazinamide as well as maximum dosing requirements, also added option for HIV-positive use requiring CD4 count ≥ 100 cells/mm3; references reviewed and updated. | 01.05.23 | 02.23 |
| For latent TB added bypass for isoniazid redirection and optional alternative dosing up to 600 mg/day for a 4 week regimen per NIH/CDC HIV guidelines. | 7.12.23 | 08.23 |
| 1Q 2024 annual review: referenced reviewed and updated. | 01.30.24 | |

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| 2Q 2025 annual review; Removed reference to Care1st Health plan and logos. Removed reference to retired policy AZ.CP.PMN.53 Off-Label Use policy added AHCCCS FFS Prior Authorization Guideline- Coverage of Off-Label Non-FDA Approved Indications. | 02.10.25 | |

**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 judgement and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**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.