

**Louisiana Medicaid
Sulopenem etzadroxil/Probenecid (Orlynvah™)**

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for sulopenem etzadroxil/probenecid (Orlynvah™).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available [HERE](#).

Approval Criteria

- The recipient is 18 years of age or older on the date of the request; **AND**
- **ALL** of the following apply and are **stated on the request**:
 - The recipient has a diagnosis of an uncomplicated urinary tract infection (uUTI) caused by the designated microorganisms *Escherichia coli*, *Klebsiella pneumoniae*, or *Proteus mirabilis*; **AND**
 - Culture and sensitivity testing has identified the pathogen and demonstrated susceptibility to the requested medication; **AND**
 - The recipient has limited or no alternative treatment options.

Duration of authorization approval: 5 days

Reference

Orlynvah (sulopenem etzadroxil/probenecid) [package insert]. Chicago, IL: Iterum Therapeutics U.S. Limited; March 2025. <https://www.orlynvah.com/pdf/prescribing-information.pdf>

Revision / Date	Implementation Date
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