OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process**.

Drug Requested: **Gattex®** (teduglutide [rDNA Origin]) **Injection**

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

- **Teduglutide has an associated REMS program**

CLINICAL CRITERIA: Check below **ALL** that apply. Boxes **must** be checked to qualify to ensure authorization will **NOT** be delayed.

- ❑ Patient is dependent on parenteral nutrition therapy ≥ 3 times per week for ≥ 12 continuous months and failed previous trials of weaning

AND

- ❑ Patient has a diagnosis of short bowel syndrome

AND

- ❑ Patient has received a colonoscopy or alternate imaging with removal of polyps (if necessary) within **six (6) months** prior to initiation of therapy

Medication being provided by a Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED:** ~~8/26/2017;~~ **8/20/2018**