

OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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. Authorization process will be delayed if incomplete.

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 or authorization process will 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.