OPTIMA HEALTH PLAN

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. 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: ❑ **Briova SpecialtyRx**

*****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 #: _____

***Approved by Pharmacy and Therapeutics Committee**: 11//20/2014
REVISED/UPDATED: ~~1/26/2015; 5/21/2015; 12/27/2015; 12/16/2016; 9/18/2017;~~ **10/6/2017**;