

# 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: \_\_\_\_\_

**CLINICAL CRITERIA:** Check boxes below that apply to qualify. **ALL** medical documentation **MUST** be included with this request form or authorization process will be delayed..

The following criteria **MUST** be met:

Member's current weight: \_\_\_\_\_ kg

Final dose per day: \_\_\_\_\_ mg (Max 3.8mg dose per vial)

SrCr: \_\_\_\_\_ (For renal impairment [CrCl <50ml/min] dose must be reduced by 50%)

**Initial 6 Month Approval** (All information **MUST** be noted or submitted with request form):

- Patient has been dependent on parenteral nutrition/intravenous fluids (PN/IV) therapy  $\geq 3$  times per week for  $\geq 12$  continuous months **and** failed previous trials of weaning (attach supportive documentation demonstrating the requirement of parenteral support)
- Frequency of current PN/IV use: \_\_\_\_\_ /week
  - Baseline of volume: \_\_\_\_\_ L/week or per infusion
  - Member's Body Mass Index (BMI): \_\_\_\_\_ kg/m<sup>2</sup>

**AND**

- Patient has a diagnosis of short bowel syndrome

**OR**

- Short bowel syndrome due to Crohn's disease with documentation of clinical remission of Crohn's disease (attach supportive documentation demonstrating the clinical remission of Crohn's disease)

**AND**

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

Date of colonoscopy (must be within 6 months): \_\_\_\_\_

**EXCLUSIONS:**

- Age <18 years
- Diagnosis of active cancer within the last 5 years
- Body Mass Index (BMI) is <15 kg/m<sup>2</sup>
- Patient received human growth hormone (e.g. Zorbtive) within the last 6 months
- Patient has had four or more SBS-related hospital admissions within the last 12 months
- Patient has an active intestinal obstruction

**For 1<sup>st</sup> Continuation of Therapy for six (6) months** (**ALL** lines below need to be completed):

- Has patient had at least 20% reduction from baseline in parenteral nutrition/intravenous fluid (PN/IV)?  YES  NO
- Frequency of current PN/IV use: \_\_\_\_\_ /week
- Six (6) months from baseline: \_\_\_\_\_ L/week or per infusion (attached supportive documentation)

(continued on next page)

- Member's Body Mass Index (BMI): \_\_\_\_\_ kg/m<sup>2</sup>
- Patient does not have any FDA labeled contraindications to therapy:  YES  NO
- Labs **MUST** be submitted every six (6) months and colonoscopy one (1) year after initiation of therapy (**MUST** attach supportive documentation)

**For 2<sup>nd</sup> Continuation of Therapy (One (1) year after initial approval) – Approval for six (6) months (ALL lines below need to be completed):**

- Has patient had at least 20% reduction from last parenteral nutrition/intravenous fluid (PN/IV)?  YES  NO
- Frequency of current PN/IV use: \_\_\_\_\_ /week
- Volume: \_\_\_\_\_ L/week or per infusion (**MUST** attach supportive documentation)
- Member's Body Mass Index (BMI): \_\_\_\_\_ kg/m<sup>2</sup>
- Patient does not have any FDA-labeled contraindications to therapy:  YES  NO
- Labs **MUST** be submitted every 6 months and colonoscopy one 1 year after initiation of therapy and then every 5 years after (**MUST** attach supportive documentation)

**For Continuation of Therapy (> 1.5 years after initial approval) – Approval for six (6) months (ALL lines need to be completed):**

- Has patient's use of parenteral nutrition/intravenous fluid (PN/IV) stabilized and not increased from last baseline six (6) months ago? (*If NO is checked, it will be denied*)  YES  NO
- Frequency of current PN/IV use: \_\_\_\_\_ /week
- Volume: \_\_\_\_\_ L/week or per infusion (**MUST** attach supportive documentation)
- Member's Body Mass Index (BMI): \_\_\_\_\_ kg/m<sup>2</sup>
- Patient does not have any FDA-labeled contraindications to therapy:  YES  NO
- Labs **MUST** be submitted every 6 months and colonoscopy 1 year after initiation of therapy and then every 5 years after (**MUST** attach supportive documentation)

**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 #: \_\_\_\_\_

\*Approved by Pharmacy and Therapeutics Committee: 11/20/2014  
REVISED/UPDATED: 4/26/2015; 5/21/2015; 4/27/2015; 4/16/2016; 8/13/2017; 3/31/2018