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 ***≥ 3 times per week*** for ***≥ 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^2

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^2
- 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 1st 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)

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- Member's Body Mass Index (BMI): _____ kg/m^2
- 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 2nd 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^2
- 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^2
- 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: ~~1/26/2015; 5/21/2015~~; ~~12/27/2015~~; ~~12/16/2016~~; ~~8/13/2017~~; **3/31/2018**;