

GATTEX

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:	
<input type="checkbox"/> Short bowel syndrome (SBS) <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. What is the patient's weight? _____ (kg)
2. Is the patient currently treated with the requested agent?..... Yes No
3. Does the patient have less than 200 cm of functional small intestine remaining? **Please submit medical records including chart notes**..... Yes No
4. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., gastroenterologist) or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No
5. Does the patient have any FDA labeled contraindications to the requested agent?..... Yes No
If yes, please specify FDA labeled contraindications: _____
6. Is the patient's age within FDA labeling for the requested indication for the requested agent?..... Yes No
If no, please provide support for using the requested agent for the patient's age for the requested indication: _____
7. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer?..... Yes No
8. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? **Please note, chart notes are required**..... Yes No
9. If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration?..... Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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Please submit chart notes to support the answers to the following questions:

10. Has the patient tried and had an inadequate response to maximal use of TWO anti-diarrheal agents (e.g., loperamide AND diphenoxylate) used concomitantly with oral rehydration solution? Yes No
11. Was maximal use of TWO anti-diarrheal agents (e.g., loperamide AND diphenoxylate) used concomitantly with oral rehydration solution discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
12. Does the patient have an intolerance or hypersensitivity to maximal use of TWO anti-diarrheal agents (e.g., loperamide AND diphenoxylate) used concomitantly with oral rehydration solution? Yes No
13. Does the patient have an FDA labeled contraindication to ALL anti-diarrheal agents (e.g., loperamide AND diphenoxylate) used concomitantly with oral rehydration solution? Yes No
14. Is maximal use of TWO anti-diarrheal agents (e.g., loperamide AND diphenoxylate) used concomitantly with oral rehydration solution expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
15. Is maximal use of TWO anti-diarrheal agents (e.g., loperamide AND diphenoxylate) used concomitantly with oral rehydration solution is not in the best interest of the patient based on medical necessity? Yes No
16. Has the patient tried another drug in the same pharmacologic class or with the same mechanism of action as TWO anti-diarrheal agents (e.g., loperamide AND diphenoxylate) used concomitantly with oral rehydration solution and that drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
17. Is the patient currently receiving parenteral nutrition/intravenous fluids (PN/IV) at least 3 days per week? **Please submit medical records, including daily volume of parenteral nutrition and/or intravenous fluids.** Yes No

For adult patients:

18. Has the patient had a colonoscopy and upper GI endoscopy within 6 months of initiating treatment with the requested agent? Yes No
Please submit medical records including the date of the last colonoscopy.
 If yes, were polyps present at this colonoscopy and upper GI endoscopy? Yes No
 If yes, were the polyps removed?..... Yes No

For pediatric patients at least 1 year of age:

19. Has a fecal occult blood test been performed within 6 months prior to initiating treatment with the requested agent? Yes No
 If yes, was there new or unexplained blood in the stool?..... Yes No
 If yes, was a colonoscopy/sigmoidoscopy and upper GI endoscopy performed? Yes No

For renewal requests:

20. Has the patient had clinical benefit with the requested agent? Yes No

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
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BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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