SENTARA COMMUNITY PLAN
(MEDICAID)

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. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Gattex® (teduglutide [rDNA Origin]) **Injection**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

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%)**

Recommended Dosage:

- **Maximum approval for adults: 0.05mg/kg once daily**
- **Maximum approval for pediatric patients ≥ 10kg: 0.05mg/kg dose once daily**

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Approval Length: 6 months. (All information must be noted or submitted with request form.)

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- ❑ Member 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

- ❑ Member must have 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

- ❑ Member 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 <1 year old **OR** ≤ 10 kg
- Diagnosis of active cancer within the last 5 years
- Body Mass Index (BMI) is <15 kg/m^2
- Member received human growth hormone (e.g. Zorbtive) within the last 6 months
- Member has had four or more SBS-related hospital admissions within the last 12 months
- Member has an active intestinal obstruction

First Continuation of Therapy: 6 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Has member 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 **(supportive documentation must be attached)**
- ❑ Member's Body Mass Index (BMI): _____ kg/m^2
- ❑ Member 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 **(supportive documentation must be attached)**

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Second Continuation of Therapy: (1 year after initial approval) 6 months. (All lines below need to be completed)

- ❑ Has member 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 **(supportive documentation must be attached)**
- ❑ Member's Body Mass Index (BMI): _____ kg/m^2
  - ❑ Member 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 **(supportive documentation must be attached)**

Continuation of Therapy - > 1.5 years after initial approval: 6 months. (All lines below need to be completed)

- ❑ Has member'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 **(supportive documentation must be attached)**
- ❑ Member's Body Mass Index (BMI): _____ kg/m^2
- ❑ Member 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 (supportive documentation must be attached)**

Medication being provided by 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.*

***REVISED/UPDATED/REFORMATTED:** ~~8/26/2017; 8/20/2018;12/24/2019;~~ **11/7/2023**