Gattex

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____Date: _____
Patient's ID: _____ Patient's Date of Birth: _____
Physician's Name: _____
Specialty: _____ NPI#: _____
Physician Office Telephone: _____ Physician Office Fax: _____
Request Initiated For: _____

ICD-10 Code: _____ Diagnosis: _____
Prescribed Drug and Dosage Form: _____
Is a loading dose required: ❑ Yes ❑ No
Prescribed Loading dose and duration: _____

Maintenance Dose and Frequency: _____

1. What is the diagnosis?
   ❑ Short bowel syndrome
   ❑ Other _____

2. Is the patient currently receiving therapy with the requested drug? *If Yes, skip to #6* ❑ Yes ❑ No

3. If the patient is an adult (18 years of age or older), *skip to #5*
   If the patient is less than 18 years of age, *continue to #4*

4. Has the patient been receiving parenteral nutrition and/or intravenous (IV) fluids to account for at least 30% of caloric and/or fluid/electrolyte needs? ***ACTION REQUIRED: If Yes, attach chart notes supporting the use of parenteral nutrition/IV fluids accounting for at least 30% of caloric and/or fluid/electrolyte needs and skip to #10.*** ❑ Yes ❑ No *If No, no further questions.*

5. Has the patient been dependent on parenteral nutrition and/or intravenous (IV) fluids at least 3 times a week for at least 12 months? ***ACTION REQUIRED: If Yes, attach chart notes supporting the use of parenteral nutrition/IV fluids at least 3 times a week for 12 months and current volume of parenteral support in liters per week and skip to #10.***
   ❑ Yes, *indicate volume of parenteral support in liters per week* _____ L/week
   ❑ No, *no further questions.*

6. Does the patient remain dependent on parenteral nutrition and/or intravenous (IV) fluids?
   ACTION REQUIRED: If Yes, attach chart notes supporting the continued use of parenteral nutrition/IV fluids.
   ❑ Yes ❑ No *If No, skip to #8*

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

7. Has the patient's requirement for parenteral support decreased by at least 20% from baseline while on therapy with the requested drug? ***ACTION REQUIRED: Attach chart notes on the current volume of the parenteral support needed in liters per week?*** *If Yes, skip to #10* ❑ Yes ❑ No *If No, no further questions.*

8. Was the patient previously dependent on parenteral nutrition and/or IV fluids? ***ACTION REQUIRED: If Yes, attach chart notes of volume of parenteral support in liters per week required at baseline.*** ❑ Yes ❑ No

9. Has the patient been able to wean off the requirement for parenteral support while on therapy with the requested drug? ***ACTION REQUIRED: If Yes, attach chart notes of volume of parenteral support in liters per week required at baseline.***
   ❑ Yes, *indicate volume of parenteral support in liters per week* _____ L/week
   ❑ No, *no further questions.*

10. Does the prescribed dose exceed 0.05 mg/kg? ❑ Yes ❑ No

11. Is the prescribed frequency more frequent than one dose daily? ❑ Yes ❑ No

12. What is the patient's body weight? *Indicate weight in kilograms or pounds.* _____ lbs/kg (circle one)

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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