HIGHMARK HEALTH OPTIONS

Updated: 07/2024
DMMA Approved: 07/2024

Request for Prior Authorization for Gattex (teduglutide)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Gattex (teduglutide) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Gattex (teduglutide Prior Authorization Criteria:

Coverage may be provided with a diagnosis of short bowel syndrome (SBS) and the following criteria is met:

- The member must be 1 year of age or older
- Must be prescribed by or in consultation with a gastroenterologist
- Documentation the member is dependent on parenteral support
- Documentation the following has occurred within 6 months prior to initiating Gattex (teduglutide):
    - Members 18 and older: a colonoscopy was performed and polyps have been removed
    - Members under 18: a fecal occult blood test has been performed and if there was unexplained blood in the stool a colonoscopy/sigmoidoscopy has been performed
- Documentation of baseline PN/IV frequency and volume
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 6 months

- **Reauthorization criteria**
    - Documentation of at least one of the following:
        - The member has at least a 20% reduction in weekly PN/IV volume from baseline
        - The member has achieved enteral autonomy
        - The member has had a reduction in parenteral support infusion of ≥1 day per week
- **Reauthorization Duration of Approval: 12 months**

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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GATTEX (TEDUGLUTIDE) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:00am to 7:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No		

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: ☐ Short Bowel Syndrome ☐ Other: _____ ICD-10 Code: _____

Please mark one of the following:

The member is 18 or older and has had a colonoscopy (within 6 months) and polyps have been removed (if applicable)
☐ Yes ☐ No

The member is under 18 and has had a fecal occult blood test (within 6 months) and if there was unexplained blood in the stool a colonoscopy/sigmoidoscopy has been performed ☐ Yes ☐ No

Is the member dependent on parenteral support? ☐ Yes ☐ No

Please provide the member's baseline parenteral nutrition/IV fluid usage. (Please include both frequency and volume): __
_____

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Please provide the member's baseline parenteral nutrition/IV fluid usage. (Please include both frequency and volume): __
_____

Please provide the member's current parenteral nutrition/IV fluid usage. (Please include both frequency and volume): __
_____

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date