HIGHMARK WHOLECARE

Updated: 7/2024
Approved: 8/2024

Prior Authorization Criteria

Gattex (teduglutide)

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

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 has a history of being 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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication 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 Wholecare Pharmacy Services. **FAX:** (888) 245-2049

If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (800) 392-1147 Mon – Fri 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
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:	

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:	ICD 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