Gateway Health℠ It's Wholecare.

Updated: 09/2021
PARP Approved: 11/2021

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 Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Frequency:	Duration:	
Is the member currently receiving requested medication? ☐ Yes ☐ No		Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a 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: _____
Does the member have a history of being 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)

Please provide at least one of the following:

1. 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): __
_____
2. Has the member achieved enteral autonomy? ☐ Yes ☐ No
3. Has the member had a reduction in parenteral support infusion of ≥1 day per week? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date

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