

Ticket #: _____ Request Date: _____ Request Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of Gattex® teduglutide. Based on recent clinical information, we require more information before this prescription can be paid by the patient's pharmacy benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information			
Patient Name:		Plan Name/Plan ID:	
Patient ID:		Patient Date of Birth:	Patient Contact Phone #:
B. Physician Information			
Physician Name:		Physician Address:	
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:
C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:
D. Clinical Information (Please fill out the following information: circle all that apply)			
1. Is this an adult patient that has Short Bowel Syndrome (SBS)?		YES	NO
2. Is the patient dependent on parenteral support (12+ months, requiring parenteral nutrition at least 3x/week)?		YES	NO
3. If YES to #2, please move to question #4. If NO, how long has patient been dependent on parenteral support, and document rationale below for coverage. Please document improvement if requesting reauthorization.			

4. Has a baseline serum bilirubin, alkaline phosphatase, lipase, amylase with colonoscopy of entire colon and removal of polyps [all within 6 months prior to initiation] been performed? If this is for reauthorization, labs need to be done every 6 months and colonoscopy 1 year after start and then every 5 years after that. (Please send results or document below.)		YES	NO

<u>Dosing Recommendation:</u> 0.05mg/kg subcutaneous injection once daily (in renal impairment (Crcl < 50ml/min) dose is reduced by 50%).			
5. Provide patient weight to be used: _____ <input type="checkbox"/> lbs or <input type="checkbox"/> kg (choose one)			
6. Enter final dose per day: _____ mg (Max 3.8mg dose per vial)			
<i>Approval = 24 weeks duration only.</i>			
Authorized Medical Signature:			
Telephone:		Date:	

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.

Prior authorization forms are reviewed at least annually and are available at www.procarerx.com. Medical Review Criteria are reviewed at least annually. Revised 09/2015