MC-Rx Powered by ProCare Rx

Gattex® teduglutide

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.

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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

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Dosing Recommendation: 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: __________ ☐ lbs or ☐ kg (choose one)
6. Enter final dose per day: __________mg (Max 3.8mg dose per vial)

Approval = 24 weeks duration only.

Authorized Medical Signature:	
Telephone:	**Date:**

When Completed Return To:

MC-Rx 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.