Prescriber Criteria Form

Gattex 2025 PA Fax 938-A v1 010125.docx
Gattex (teduglutide)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Gattex (teduglutide).

Drug Name:
Gattex (teduglutide)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of short bowel syndrome? [If no, then no further questions.]	Yes ◯	No ◯
2	Is the patient currently receiving therapy with the requested medication? [If yes, then skip to question 6.]	Yes ◯	No ◯
3	Is this request for a pediatric patient? [If no, then skip to question 5.]	Yes ◯	No ◯
4	Is the patient dependent on parenteral support? [If yes, then skip to question 7.] [If no, then no further questions.]	Yes ◯	No ◯
5	Has the patient been dependent on parenteral support for at least 12 months? [If yes, then skip to question 7.] [If no, then no further questions.]	Yes ◯	No ◯
6	Has the patient's requirement for parenteral support decreased from baseline while on therapy with the requested drug? [If no, then no further questions.]	Yes ◯	No ◯

7	Is the requested drug being prescribed by or in consultation with a gastroenterologist, gastrointestinal surgeon, or nutritional support specialist?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____