**UPMC Health Plan**

**GATTEX**

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762) FAX 412-454-7722

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**PLEASE TYPE OR PRINT NEATLY**

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

<table>
<thead>
<tr>
<th>Office Contact:</th>
<th>Provider Specialty:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider First Name:</td>
<td>Provider Last Name:</td>
</tr>
<tr>
<td>Provider Phone:</td>
<td>Provider Fax:</td>
</tr>
<tr>
<td>Patient Name:</td>
<td>Patient UPMC Health Plan ID Number:</td>
</tr>
</tbody>
</table>

**Drug Requested:**

- [ ] New Medication
- [ ] Ongoing Medication

**Diagnosis:**

If Ongoing Provide Date Started: ____________________________

If medication is ongoing, did the member show improvement while on therapy?  
- [ ] Yes
- [ ] No

Please indicate place of administration?  
- [ ] Physician’s Office
- [ ] Hospital/Facility
- [ ] Patient Home

Please indicate how medication will be billed:  
- [ ] Billed directly by the provider via JCODE Provide JCODE: ____________________________
- [ ] Billed by a pharmacy and delivered to the provider
- [ ] Billed by a pharmacy and delivered to the patient

Please provide facility/provider name and address:

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**Medical History**

Does the member have a diagnosis of short bowel syndrome?  
- [ ] Yes  
- [ ] No

Please indicate length of residual functional small intestine (in cm): ________________

Has the member had a bowel resection?  
- [ ] Yes  
- [ ] No

If yes, please provide date of procedure: ________________

Is the member receiving parenteral or intravenous nutrition support?  
- [ ] Yes  
- [ ] No

Please provide the following:

- Frequency: ____________________________
- Volume per infusion: ____________________________

Does the member have an active malignancy?  
- [ ] Yes  
- [ ] No

Does the member have active intestinal obstruction?  
- [ ] Yes  
- [ ] No

Did the member have a recent (within 6 months) colonoscopy?  
- [ ] Yes  
- [ ] No

Please provide date: ____________________________

Did the member have recent (within 6 months) bilirubin, alkaline phosphatase, lipase, and amylase levels?  
- [ ] Yes  
- [ ] No

Please provide date: ____________________________

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Please be sure to complete and include the 2nd page of this form.

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Gattex PA Form  
All PA forms available at [www.upmchealthplan.com/providers/pa_forms.html](http://www.upmchealthplan.com/providers/pa_forms.html)  
February 2013
<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Patient UPMC Health Plan ID Number</th>
<th>Patient DOB</th>
</tr>
</thead>
</table>

Please be sure to complete and include this page with the 1st page of this form

Is this request for reauthorization?
- ☐ Yes
- ☐ No

If yes, please include the following documentation:
- ☐ Documentation showing member’s disease has stabilized, including any changes in parenteral or intravenous nutrition schedule
- ☐ Documentation of no active malignancy or active intestinal obstruction
- ☐ Documentation that bilirubin, alkaline phosphatase, lipase, and amylase levels are being monitored at least every 6 months.
- ☐ Documentation of follow-up colonoscopy (if appropriate) after 1 year of treatment, then at least every 5 years

Please provide any additional information which should be considered in the space below:

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Gattex PA Form

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February 2013