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

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.

Office Contact:	**Provider Specialty:**		
Provider First Name:	**Provider Last Name:**		
Provider Phone:	**Provider Fax:**	**Provider NPI #:**	
Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**
Drug Requested: ☐ **Brand** ☐ **Generic**	**Strength:**	**Frequency:**	**Qty Dispensed:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐ **New Medication** ☐ **Ongoing Medication**	**If Ongoing Provide Date Started:**	**If medication is ongoing, did the member show improvement while on therapy?**	☐ **Yes** ☐ **No**
Diagnosis:		**Date of diagnosis:**	

Please indicate place of administration?
☐ Physician's Office
☐ Hospital/Facility
☐ Patient Home

Please provide facility/provider name and address:

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

Medical History

Does the member have a diagnosis of short bowel syndrome? Please indicate length of residual functional small intestine (in cm): _____	☐ **Yes** ☐ **No**
Has the member had a bowel resection? If yes, please provide date of procedure: _____	☐ **Yes** ☐ **No**
Is the member receiving parenteral or intravenous nutrition support? Please provide the following: Frequency: _____ Volume per infusion: _____	☐ **Yes** ☐ **No**
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? Please provide date: _____	☐ **Yes** ☐ **No**
Did the member have recent (within 6 months) bilirubin, alkaline phosphatase, lipase, and amylase levels? Please provide date: _____	☐ **Yes** ☐ **No**

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

GATTEX

Page 2

Patient Name	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**

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

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

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