carolina complete health

Pharmacy Prior Approval Request for Gattex

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days:_____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

For initial authorization requests:
1. Is the beneficiary age 1 or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary have a diagnosis of short bowel syndrome (SBS)? ☐ **Yes** ☐ **No**
3. Has the beneficiary been dependent on parenteral nutrition for at least 12 months? ☐ **Yes** ☐ **No**
4. Is the beneficiary receiving parenteral nutrition at least 3 times per week? ☐ **Yes** ☐ **No**

For reauthorization requests:

5. Is the beneficiary continuing to receive parenteral nutrition while taking Gattex? ☐ **Yes** ☐ **No**

Signature of Prescriber:_____Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/