CVS caremark™ {{PANUMCODE}}

Gattex

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the diagnosis?
   ❑ Short bowel syndrome
   ❑ Other _____
2. What is the ICD-10 code? _____
3. What is the patient's body weight? _____ kg/lbs ***(circle one)***
4. What is the prescribed dose? _____ mg/kg every _____ day(s)
5. Is the patient currently receiving therapy with the requested drug? *If Yes, skip to #8* ❑ Yes ❑ No
6. *If the patient is less than 18 years of age*, has the patient been receiving intravenous nutrition/fluids to account for at least 30% of caloric and/or fluid/electrolyte needs? ***ACTION REQUIRED: If Yes, attach chart notes supporting the use of parenteral nutrition/IV fluids for at least 30% of caloric and/or fluid/electrolyte needs.***
   ❑ Yes ❑ No *No further questions*
7. *If the patient is 18 years of age or older*, has the patient been dependent on parenteral nutrition and/or intravenous fluids at least 3 times a week for at least 12 months? ***ACTION REQUIRED: If Yes, attach chart notes supporting the use of parenteral nutrition/IV fluids at least 3 times a week for 12 months and current volume of parenteral support in liters per week.***
   ❑ Yes ❑ No *No further questions*
8. Does the patient remain dependent on parenteral nutrition and/or intravenous fluids? ***ACTION REQUIRED: If Yes, attach chart notes supporting the continued use of parenteral nutrition/IV fluids and the current volume of parenteral support needed in liters per week.*** ❑ Yes ❑ No *If No, skip to #11*
9. Has the patient's requirement for parenteral support decreased by at least 20% from baseline while on therapy with the requested drug? ❑ Yes ❑ No
10. What volume of parenteral support is the patient currently receiving in liters/week? _____ L/wk
    No further questions

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

11. Was the patient previously dependent on parenteral nutrition and/or intravenous fluids and has been able to wean off the requirement for parenteral support while on therapy with the requested drug? ***ACTION REQUIRED: If Yes, attach chart notes of volume of parenteral support in liters per week required at baseline.*** ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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