Gattex Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.

1. Patient information	**2. Physician information**
Patient name: ______________________	Prescribing physician: ______________________
Patient ID #: ______________________	Physician address: ______________________
Patient DOB: ______________________	Physician phone #: ______________________
Date of Rx: ______________________	Physician fax #: ______________________
Patient phone #: ______________________	Physician specialty: ______________________
Patient email address: ______________________	Physician DEA: ______________________
	Physician NPI #: ______________________
	Physician email address: ______________________

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Gattex			Specify:

7. Diagnosis:

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

☐ Yes ☐ No Does the client have a diagnosis of short bowel syndrome in the last 730 days?

☐ Yes ☐ No Is the client currently dependent on parenteral support?

☐ Yes ☐ No Has the client had a colonoscopy in the last 180 days?

☐ Yes ☐ No Has the client had fecal occult blood testing in the last 180 days?

☐ Yes ☐ No Does the client have a diagnosis of intestinal or stomal obstruction in the last 180 days?

☐ Yes ☐ No Does the client have a diagnosis of moderate to severe renal impairment or end-stage renal disease in the last 365 days?

☐ Yes ☐ No Does the client continue to receive clinical benefit from treatment with Gattex?

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **https://www.txvendordrug.com/formulary/formulary-search**

9. Physician signature

______________________________ ______________________

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the

applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.
The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.