Trillium Health Resources
Pharmacy Prior Approval Request for

Gattex

Member Information

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

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Gattex** 2. Strength: _____ 3. Quantity per 30 Days: _____
4. 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 member age 1 or older? ☐ **Yes** ☐ **No**
2. Does the member have a diagnosis of short bowel syndrome (SBS)? ☐ **Yes** ☐ **No**
3. Has the member been dependent on parenteral nutrition for at least 12 months? ☐ **Yes** ☐ **No**
4. Is the member receiving parenteral nutrition at least 3 times per week? ☐ **Yes** ☐ **No**

For reauthorization requests answer questions 1-5:

5. Is the member 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 PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277