Gattex

HMSACOM - 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 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** 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: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

 Gattex HMSACOM C11016-A – 04/2026.

Criteria Questions:

1. What is the diagnosis?
❒ Short bowel syndrome (SBS), *Continue to #2*
❒ Other, *Continue to #2*

2. Is this request for a new start or continuation of Gattex therapy?
❒ New start, *Continue to #8*
❒ Continuation, *Continue to #3*

3. Was Gattex therapy previously authorized by HMSA/CVS for this member?
❒ Yes, *Continue to #4*
❒ No, *Continue to #8*
❒ Unknown, *Continue to #8*

Continuation Criteria – SBS

4. Does the member remain dependent on parenteral nutrition and/or intravenous (IV) fluids?
❒ Yes, *Continue to #5*
❒ No, *Continue to #6*

5. Has the member's requirement for parenteral support decreased by at least 20% from baseline while on Gattex therapy? *If yes, please attach supporting chart notes*
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

6. Was the patient previously dependent on parenteral nutrition and/or IV fluids and has been able to wean off the requirement for parenteral support while on therapy with the requested drug? *If yes, please attach supporting chart notes.*
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Initial Criteria – SBS Adult

8. What is the member's age?
❒ Greater than or equal to 18, *Continue to #9*
❒ Less than 18 years of age, *Continue to #15*

9. Has the member been dependent on parenteral nutrition and/or intravenous (IV) fluids for at least 12 months? *If yes, please attach chart notes supporting the use of parenteral nutrition/intravenous (IV) fluids*
❒ Yes, *Continue to #10*
❒ No, *Continue to #10*

10. Is the member receiving parenteral nutrition and/or IV fluids at least 3 times per week? *If yes, please attach supporting chart notes*
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Initial Criteria – SBS Pediatric

15. Is the member receiving parenteral nutrition and/or IV fluids to account for at least 30% of caloric and/or

fluid/electrolyte needs? *If yes, please attach supporting chart notes*
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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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