Gattex® (teduglutide) Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form.

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:	Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.				
Address:	City:	State:	ZIP:		
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:	Office Contact Name:	Phone:			

Specialty *(Check one)*: ☐ **Endocrinologist** ☐ **Internist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Gattex (teduglutide): Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (please ensure dosage and patient's weight is completed above):

☐ Yes ☐ No Has the patient been diagnosed with short bowel syndrome?

For Initiation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Is this request for a patient less than 18 years of age?
- ☐ Yes ☐ No Has the patient been dependent on parenteral nutrition and/or intravenous (IV) fluids at least 3 times a week for at least 12 months?
  - Please provide the start date of support: ____/____/____
  - How many times a week does the patient require parenteral nutrition: _____ / per week
- ☐ Yes ☐ No Has the patient been receiving parenteral nutrition and/or intravenous (IV) fluids to account for at least 30% of caloric and/or fluid electrolyte needs?
  - Please provide the start date of support: ____/____/____
  - How many times a week does the patient require parenteral nutrition: _____ / per week

For Continuation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Does the patient remain dependent on parenteral nutrition and/or intravenous (IV) fluids?
- ☐ Yes ☐ No 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?
  - Please provide the baseline weekly parenteral volume support requirement (prior to start of the requested drug treatment) _____Liters/per week

☐ Yes ☐ No Has the patient's requirement for parenteral support decreased by at least 20% from baseline while on therapy with the requested drug?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.