AmeriHealth Caritas North Carolina

# Pharmacy Request for Prior Approval – Gattex

**Beneficiary Information**

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

**Prescriber Information**

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

**Drug Information**

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

**Clinical Information**

**Initial Requests:**

1. Is the beneficiary age 1 or older? Yes___ No___
2. Does the beneficiary have a diagnosis of short bowel syndrome (SBS)? Yes___ No___
3. Has the beneficiary been dependent on parenteral nutrition for at least 12 months? Yes___ No___
4. Is the beneficiary receiving parenteral nutrition at least 3 times per week? Yes___ No___

**Continued Therapy**

5. Is the beneficiary 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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406**