Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Gattex

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the medication prescribed by or in consultation with a gastroenterologist or a colorectal surgeon?

☐ Yes ☐ No

Q2. Does the patient have a documented diagnosis of short bowel syndrome?

☐ Yes ☐ No

Q3. Is the patient greater than or equal to 18 years of age and currently receiving parenteral nutrition or intravenous fluids for at least 12 months and at least three or more days a week or is the member less than 18 years of age and receiving parenteral nutrition or intravenous fluids that account to at least 30% of caloric or fluid/ electrolyte needs despite optimized dietary modifications and medical treatment (antimotility and antisecretory agents as appropriate)?

☐ Yes ☐ No

Q4. Does the patient have active gastrointestinal malignancy?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Does the patient have biliary and/or pancreatic disease?

☐ Yes ☐ No

Q6. If 18 years or older, is there documentation of colonoscopy to rule out polyps within the last 6 months?

☐ Yes ☐ No

Q7. Is the prescription within the FDA-labeled dose of 0.05 mg/kg/day?

☐ Yes ☐ No

Q8. Additional Information:

_____ _____

Prescriber Signature Date

2024 Prior Authorization Request