HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Gattex - Non-PDL

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

HPP's maximum approval time is 12 months but may be less depending on the drug.

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

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

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☐ Yes ☐ No

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

☐ Yes ☐ No ☐ Under 18 - N/A

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

☐ Yes ☐ No

Q8. Additional Information:

Prescriber Signature

Date

v2025