

GI MOTILITY, CHRONIC – CONSTIPATION-RELATED DIAGNOSES PRIOR AUTHORIZATION FORM

Prior authorization guidelines and quantity limits for **GI Motility, Chronic** agents and **Quantity Limits/Daily Dose Limits** are accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request:	Prescriber name:	
<input type="checkbox"/> Renewal request	PA# _____	_____	Specialty:	
Name of office contact:			State license #:	
Contact's phone number:			NPI:	
LTC facility contact/phone:			MA Provider ID#:	
RECIPIENT INFORMATION			Street address:	
Recipient Name:			Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Preferred medication requested (clinical PA required):	<input type="checkbox"/> Amitiza capsule	<input type="checkbox"/> Linzess capsule
Non-preferred medication requested:	<input type="checkbox"/> Movantik tablet	<input type="checkbox"/> Relistor 12 mg/0.6 ml syringe
	<input type="checkbox"/> Relistor 12 mg/0.6 ml vial	<input type="checkbox"/> Relistor 8 mg/0.4 ml syringe
Strength:	Dose/directions:	Quantity: Refills:
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):

ALL INITIAL and RENEWAL requests

1. Does the Recipient have a known or suspected gastrointestinal (GI) obstruction?	<input type="checkbox"/> Yes – <i>submit documentation.</i>	<input type="checkbox"/> No
2. Have all drug interactions with the requested medication been addressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <i>Submit Recipient's complete medication list.</i>

ALL INITIAL requests

3. Does the Recipient have one of the following diagnoses? <i>Check applicable diagnosis.</i>	<input type="checkbox"/> Yes – <i>submit documentation of diagnosis.</i>
<input type="checkbox"/> irritable bowel syndrome with constipation (IBS-C) <input type="checkbox"/> chronic idiopathic constipation (CIC) <input type="checkbox"/> opioid-induced constipation (OIC)	<input type="checkbox"/> No – <i>submit documentation supporting the use of the requested agent for the Recipient's diagnosis.</i>
4. Does the Recipient have a history of trial and failure, contraindication, or intolerance of an agent in each of the following groupings for the treatment of constipation? <i>Check all that apply.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of all agents tried and treatment outcomes, contraindications, or intolerances.</i>
<input type="checkbox"/> fiber supplementation/high fiber diet (20-35 grams per day): _____ grams fiber/day	
<input type="checkbox"/> bulk-forming agents: <input type="checkbox"/> psyllium <input type="checkbox"/> methylcellulose <input type="checkbox"/> wheat dextran <input type="checkbox"/> calcium polycarboxiphil	
<input type="checkbox"/> osmotic agents: <input type="checkbox"/> magnesium citrate <input type="checkbox"/> glycerin <input type="checkbox"/> magnesium hydroxide <input type="checkbox"/> lactulose <input type="checkbox"/> polyethylene glycol (PEG) <input type="checkbox"/> sorbitol	
<input type="checkbox"/> stimulant laxatives: <input type="checkbox"/> bisacodyl <input type="checkbox"/> senna	
<input type="checkbox"/> suppositories: <input type="checkbox"/> bisacodyl <input type="checkbox"/> glycerin	
<input type="checkbox"/> other (list): _____	

ALL NON-PREFERRED requests

5. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred GI Motility – Constipation-Related Diagnoses medications? <i>Check all that apply.</i>	<input type="checkbox"/> Yes – <i>submit documentation of medications tried and treatment outcomes, contraindications, or intolerances.</i>
<input type="checkbox"/> Amitiza capsule <input type="checkbox"/> Linzess capsule	<input type="checkbox"/> No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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