pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

GI MOTILITY, CHRONIC – DIARRHEA-RELEATED 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	
☐New request ☐Additional info ☐Renewal request PA# _____	total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested: ☐alosetron tablet ☐Lotronex tablet ☐Viberzi tablet

Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

ALL INITIAL and RENEWAL requests

1. Have all drug interactions with the requested medication been addressed? ☐Yes ☐No *Submit Recipient's complete medication list.*

2. Does the Recipient have any contraindications to the requested agent? *Check all that apply.*

Lotronex/alosetron
- ☐chronic or severe constipation
- ☐intestinal obstruction
- ☐intestinal stricture
- ☐toxic megacolon
- ☐gastrointestinal perforation
- ☐gastrointestinal adhesions
- ☐ischemic colitis
- ☐impaired intestinal circulation
- ☐thrombophlebitis or hypercoagulable state
- ☐Crohn's disease or ulcerative colitis
- ☐diverticulitis
- ☐severe hepatic impairment

Viberzi
- ☐known or suspected biliary duct obstruction
- ☐sphincter of Oddi disease of dysfunction
- ☐alcoholism, alcohol abuse, or > 3 drinks/day
- ☐history of pancreatitis
- ☐structural diseases of the pancreas
- ☐severe hepatic impairment
- ☐history of chronic or severe constipation or sequelae from constipation
- ☐known or suspected mechanical GI obstruction

☐Yes – *submit documentation.*
☐No

3. ***Lotronex/alosetron only:*** Has the prescriber complied with the Lotronex/alosetron REMS requirements? ☐Yes ☐No

INITIAL requests

4. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the following treatments for diarrhea? *Check all that apply.*
   - ☐antidiarrheal medications (eg, loperamide)
   - ☐antispasmodic medications (eg, dicyclomine)
   - ☐*(for Lotronex/alosetron only)* standard dietary modifications for IBS-D

☐Yes – *submit documentation of treatments tried and outcomes, contraindications, or intolerances.*
☐No

5. ***Lotronex/alosetron only:*** Have other causes of chronic diarrhea been ruled out?

☐Yes – *submit all supporting documentation.*
☐No

RENEWAL requests for LOTRONEX/ALOSETRON

1. Did the Recipient experience adequate control of IBS-D symptoms after 4 weeks of treatment with Lotronex/alosetron 1 mg twice daily? ☐Yes ☐No *Submit documentation of treatment response.*
2. Does the Recipient have constipation or signs of ischemic colitis (rectal bleeding, bloody diarrhea, or new or worsening abdominal pain) since starting treatment with the requested agent? ☐Yes ☐No *Submit documentation.*

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

Prescriber Signature:	**Date**: