

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

Prior authorization guidelines for **GI Motility, Chronic Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Dosage form:	Strength:	
Dose/directions:		Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):	

INITIAL requests

Indicate all other medications and diets the beneficiary has tried or cannot try for the treatment of constipation. *Check all that apply and SUBMIT DOCUMENTATION for each.*

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 polycarbophil | |
| <input type="checkbox"/> osmotic agents: | <input type="checkbox"/> glycerin | <input type="checkbox"/> sorbitol | <input type="checkbox"/> magnesium hydroxide |
| | <input type="checkbox"/> lactulose | <input type="checkbox"/> magnesium citrate | <input type="checkbox"/> polyethylene glycol (PEG) |
| <input type="checkbox"/> oral stimulant laxatives: | <input type="checkbox"/> bisacodyl | <input type="checkbox"/> sennosides | |
| <input type="checkbox"/> suppositories: | <input type="checkbox"/> bisacodyl | <input type="checkbox"/> glycerin | |

other (list):

Requests for a non-preferred medication: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred GI Motility, Chronic Agents for the treatment of constipation? Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.

Yes
 No
Submit documentation of all agents tried and treatment outcomes, contraindications, or intolerances.

RENEWAL requests

Did the beneficiary experience a positive clinical response since starting the requested medication?

Yes
 No
Submit documentation.

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

Prescriber Signature:	Date:
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