

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

Prior authorization guidelines **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>.

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|--------------------------------------|--|--------------------|------------------|------------------|
| <input type="checkbox"/> New request | <input type="checkbox"/> Renewal request | Total 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: | Strength: | |
| Dose/directions: | Quantity: | Refills: |
| Diagnosis (<i>submit documentation</i>): | DX code (<i>required</i>): | |

Complete all sections that apply to the beneficiary and this request. Check all that apply and submit documentation for each item.

All INITIAL requests

- Tried and failed or has a contraindication or intolerance to loperamide
- Tried and failed or has a contraindication or intolerance to bile acid sequestrants (e.g., cholestyramine, colesevelam)

Lotronex (alosetron) INITIAL requests

- Has chronic IBS symptoms generally lasting 6 months or longer
- Had anatomic or biochemical abnormalities of the GI tract excluded
- Has severe diarrhea-predominant IBS that includes at least one of the following:
 - Frequent and severe abdominal pain/discomfort
 - Frequent bowel urgency or fecal incontinence
 - Disability or restriction of daily activities due to IBS

Viberzi (eluxadoline) INITIAL requests

- Has results of recent liver function tests (LFTs)

All RENEWAL requests

- Experienced a positive clinical response since starting the requested medication

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

| | |
|-----------------------|-------|
| Prescriber Signature: | Date: |
|-----------------------|-------|

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