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 AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/9/2023)*

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.

☐New request ☐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:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

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

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

INITIAL requests

1. For treatment of a CONSTIPATION-related diagnosis (eg, opioid-induced constipation, IBS with constipation, chronic idiopathic constipation):
   - ☐Tried and failed or has a contraindication or an intolerance to at least 2 of the following *(check all that apply)*:
     - ☐Bulk-forming agents (eg, calcium polycarbophil, methylcellulose, psyllium, wheat dextran)
     - ☐Fiber supplementation/high fiber diet
     - ☐Glycerin or bisacodyl suppositories
     - ☐Osmotic agents (eg, lactulose, magnesium citrate, magnesium hydroxide, polyethylene glycol [PEG], sorbitol)
     - ☐Stimulant laxatives (eg, oral bisacodyl, sennosides)
   - ☐For a non-preferred GI Motility, Chronic Agent for the treatment of constipation:
     - ☐Tried and failed or has a contraindication or an intolerance to 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.)*
2. For treatment of a DIARRHEA-related diagnosis (eg, IBS with diarrhea):
   - ☐Is prescribed the requested medication by or in consultation with a gastroenterologist *(submit documentation of consultation, if applicable)*
   - ☐For Lotronex (alosetron) *(check all that apply)*:
     - ☐Has severe diarrhea-predominant IBS that includes at least one of the following:
       - ☐Frequent and severe abdominal pain/discomfort

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- ☐ Frequent bowel urgency or fecal incontinence
- ☐ Disability or restriction of daily activities due to IBS

☐ Has chronic IBS symptoms generally lasting 6 months or longer

☐ Had anatomic or biochemical abnormalities of the GI tract excluded

☐ Has not responded adequately to conventional therapy

RENEWAL requests

☐ Experienced a positive clinical response since starting the requested medication

☐ For treatment of a diarrhea-related diagnosis (eg, IBS with diarrhea):

- ☐ Is prescribed the requested medication by or in consultation with a gastroenterologist *(submit documentation of consultation, if applicable)*

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

Prescriber Signature:	Date: