Health Partners Plans

**HEALTH PARTNERS PLANS**
***PRIOR AUTHORIZATION REQUEST FORM***

# GI Motility Agents - Chronic

**Phone: 215-991-4300** **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

| | | |
|---|---|---|
| Patient Name: | Prescriber Name: | |
| HPP Member Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Patient Primary Phone: | NPI: | *PA PROMISe ID:* |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Line of Business: ☐ Medicaid ☐ CHIP | *Specialty Pharmacy (if applicable):* | |
| **Drug Name:** | **Strength:** | |
| **Quantity:** | **Refills:** | |
| **Directions:** | | |
| **Diagnosis Code:** | **Diagnosis:** | |
| *HPP's maximum approval time is 12 months but may be less depending on the drug.* | | |

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

***Please answer the following questions and sign.***

Q1. Is the patient prescribed a dose that is consistent with Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q2. Have all potential drug interactions been addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug, or counseling the patient of the risks associated with the use of both drugs when they interact)?

☐ Yes ☐ No

Q3. Does the patient have a history of contraindication to the requested medication?

☐ Yes ☐ No

Q4. Is this a request for a renewal of authorization?
[If no, then skip to question 9.]

☐ Yes ☐ No

Q5. Does the patient have documentation of tolerability and a positive clinical response to the medication?

☐ Yes ☐ No

Q6. Is this a request for a drug indicated for the treatment of a diagnosis involving diarrhea?

☐ Yes ☐ No

Q7. Is the requested drug being prescribed by or in consultation with a gastroenterologist?

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☐ Yes ☐ No

Q8. Is this a request for alosetron (Lotronex)?

☐ Yes ☐ No

Q9. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q10. Is the requested drug age-appropriate according to Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q11. Is the requested drug indicated for treatment of a diagnosis involving constipation?

☐ Yes ☐ No

Q12. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of ALL of the following: A) laxatives, B) fiber supplementation, C) osmotic agents, D) bulk forming agents, E) glycerin or bisacodyl suppositories?

☐ Yes ☐ No

Q13. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of both loperamide AND a bile acid sequestrant?

☐ Yes ☐ No

Q14. Does the patient have a documented therapeutic failure of BOTH of the following: A) lactose, gluten, andartificial sweetener avoidance, B) a low fermentable oligosaccharides, disaccharides, and monosaccharides and polyols (FODMAP) diet?

☐ Yes ☐ No

Q15. Is this a request for a preferred chronic gastrointestinal (GI) motility agent?

☐ Yes ☐ No

Q16. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred chronic gastrointestinal (GI) motility agents approved or medically accepted for the patient's diagnosis?

☐ Yes ☐ No

Q17. Additional Information:

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Prescriber Signature

Date

*Updated for 2020*