SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Chronic GI Motility Drugs

Drug Requested: (Check box below that applies)

Preferred Medications* (must be tried and failed FIRST) ***Need trial and failure of laxative classes**		
❑ **lubiprostone**	❑ **Linzess®**	❑ **Movantik®**
Non-Preferred Medications		
❑ **alosetron**	❑ **Amitiza®**	❑ **Ibsrela®**
❑ **Lotronex®**	❑ **Motegrity®**	❑ **prucalopride**
❑ **Relistor®**	❑ **Symproic®**	❑ **Trulance®**
❑ **Viberzi®**		

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

(Continued on next page)

CLINICAL CRITERIA AND DIAGNOSIS: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Does the member have any of the following diagnoses? **(Check all that apply.)**

- ❑ Chronic Idiopathic Constipation (CIC)
- ❑ Constipation Predominant Irritable Bowel Syndrome (IBS-C)
- ❑ Functional Constipation (FC) in pediatric patients 6 to 17 years of age (Linzess 72mcg only)
  - ❑ Does the prescriber attest that other causes of constipation have been ruled out?
- ❑ Severe Diarrhea Predominant Irritable Bowel Syndrome (IBS-D)
- ❑ Opioid Induced Constipation in chronic NON-cancer pain (OIC)
- ❑ Other: _____

❑ Amitiza®/ Ibsrela®/ Linzess®/ lubiprostone/ Trulance®:

Has member had a treatment failure on at least **TWO (2)** of the following classes **in addition** to 2 of the preferred medications?

- **Osmotic Laxative s** (i.e., lactulose, polyethylene glycol, sorbitol); **OR** ❑ Yes ❑ No
- **Bulk forming Laxatives** (i.e., psyllium, fiber), **OR** ❑ Yes ❑ No
- **Stimulant Laxative s** (i.e., bisacodyl, senna)? ❑ Yes ❑ No

❑ Amitiza®/ lubiprostone/ Movantik®/ Relistor®/ Symproic® (OIC only):

Has member had treatment failure on both polyethylene glycol **AND** lactulose **in addition** to 2 of the preferred medications if non preferred medication being requested? ❑ Yes ❑ No

❑ Alosetron/ Lotronex®/ Viberzi®:

Has member had a treatment **failure on a least THREE (3) of the following classes?**

- **Bulk forming Laxatives** (i.e, psyllium, fiber) ❑ Yes ❑ No
- **Antispasmodic Agents** (i.e, dicyclomine, hyoscyamine) ❑ Yes ❑ No
- **Antidiarrheal Agents** (i.e, loperamide, diphenoxylate/atropine)? ❑ Yes ❑ No

❑ Motegrity®/ prucalopride

Has member had a treatment failure on the following? ❑ Yes ❑ No

- ≥2 preferred traditional laxative therapy (e.g., polyethylene glycol, lactulose); **AND**
- ≥1 preferred newer products indicated for CIC (e.g., linaclotide, lubiprostone)

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List pharmaceutical agents attempted and outcome:

1. _____

2. _____

3. _____

MEDICAL NECESSITY: Provide clinical evidence that the PREFERRED drugs will not provide adequate benefit.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*