UnitedHealthcare Community Plan

Chronic GI Motility Agents - Washington
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ **Yes** □ **No**	**What is the patient's diagnosis?** *(check which applies)* □ Irritable bowel syndrome with constipation (IBS-C) □ Severe irritable bowel syndrome with diarrhea (IBS-D) □ Chronic idiopathic constipation (CIC) □ Advanced illness (or terminal illness) receiving palliative care □ Opioid-induced constipation (OIC) with chronic non-cancer pain
□ **Yes** □ **No**	**Has known or suspected GI obstruction been ruled out?**
□ **Yes** □ **No**	**Has attestation from the provider been given, confirming the patient does not have a history of any contraindications for this medication?**
LOTRONEX - VIBERZI	
□ **Yes** □ **No**	**Does the patient meet one or more of the following:** *(check all that apply)* □ Frequent and severe abdominal pain/discomfort. □ Frequent bowel urgency or fecal incontinence □ Disability or restriction of daily activities due to IBS-D
□ **Yes** □ **No**	**Does the patient have a history of failure, contraindication or intolerance to ≥ 2 week trial of two of the following conventional therapies:** (If yes, complete Section D above) □ Antidiarrheal (e.g. loperamide) □ Antispasmodics (e.g. dicyclomine, hyoscyamine) □ Antibiotics □ Antidepressants (e.g. amitriptyline, sertraline) □ Bile acid sequestrants (e.g. cholestyramine, colestipol)
LINZESS – AMITIZA – TRULANCE – RELISTOR – SYMPROIC - MOVANTIK	
□ **Yes** □ **No**	**Does the patient have a history of failure, contraindication or intolerance to ≥ 2 week trial of two of the following conventional therapies: (check which applies)** □ Bulk-forming laxative (e.g. psyllium) □ Stool softener (e.g. docusate sodium) □ Osmolar agents (e.g. lactulose) □ Stimulant laxative (e.g. sennoside) □ Polyethylene glycol (e.g. Miralax)
CONTINUATION OF THERAPY	
□ **Yes** □ **No**	**Does the patient have a documented positive clinical symptomatic improvement to therapy?** *If yes, list response:*

Provider Signature: _____ Date: _____