Prior Authorization Request Form for GI Motility, Chronic-Constipation

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred GI Motility, Chronic-Constipation? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No *Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.*

- ☐ Member does not have a contraindication to the requested medication
- ☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

- ☐ Documented history of therapeutic failure, contraindication or intolerance of 2 of the following: (medication, start date and end date)
  - ☐ **Fiber supplementation/high fiber diet** (20-35 grams per day): _____ grams fiber/day
  - ☐ **Bulk-forming agents**: ☐ Psyllium ☐ Wheat Dextran ☐ Methylcellulose ☐ Calcium Polycarbophil
  - ☐ **Osmotic agents:** ☐ Glycerin ☐ Lactulose ☐ Sorbitol ☐ Magnesium Citrate ☐ Magnesium Hydroxide ☐ Polyethylene Glycol (PEG)
  - ☐ **Oral Stimulant Laxatives:** ☐ Bisacodyl ☐ Sennosides
  - ☐ **Suppositories:** ☐ Bisacodyl ☐ Glycerin
  - ☐ **Other:** _____

RENEWAL REQUESTS:

- ☐ Has the member experienced tolerability and a positive clinical response since starting requested medication evidenced by:_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :		
Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)