Prior Authorization Request Form for GI Motility, Chronic-Diarrhea

FAX this completed form to (877) 386-4695

OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group 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: _____

- ☐ Potential drug interactions addressed by the prescriber (such as discontinuation or dose reduction of interacting medication, or counseling the member of risks associated with the use of both medication)
- ☐ Member does not have a history of 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 to ALL the following: (medication, start date and end date)
  - ☐ Loperamide:_____
  - ☐ Bile Acid Sequestrant:_____
- ☐ Documented history of therapeutic failure to ALL the following:
  - ☐ Lactulose Avoidance:_____
  - ☐ Gluten Avoidance:_____
  - ☐ Artificial Sweetener Avoidance:_____
  - ☐ A low fermentable olgio-, di-, and monosaccharides and polyols (FODMAP) diet:_____
- ☐ Prescribed by or in consultation with a gastroenterologist

RENEWAL REQUESTS:

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

Envolve Pharmacy Solutions 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.)