Prior Authorization Request Form for GI Motility, Chronic Agents

FAX this completed form to (844) 205-3386
OR Mail requests to: PA 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 #:
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: _____

Does the member have a history of a contraindication to the requested medication?
☐ Yes ☐ No

Requests for all non-preferred GI Motility, Chronic Agents: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred GI Motility, Chronic Agents? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*
☐ Yes ☐ No
Medication Taken Previously(start and end date): _____

☐ 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.

CONSTIPATION-RELATED DIAGNOSIS REQUEST:

☐ Tried and failed or has a contraindication or an intolerance to at least 2 of the following (circle agent tried):
- ☐ Bulk-forming agents (eg, calcium polycarbophil, methylcellulose, psyllium, wheat dextran)
- ☐ Fiber supplementation/high fiber diet
- ☐ Glycerin or Bisacodyl suppositories
- ☐ Osmotic agents (eg, lactulose, magnesium citrate, magnesium hydroxide, polyethylene glycol [PEG], sorbitol)
- ☐ Stimulant laxatives (eg, oral bisacodyl, sennoside)

DIARRHEA-RELATED DIAGNOSIS REQUEST:

☐ Prescribed by or in consultation with a gastroenterologist

RENEWAL REQUIEST:

☐ Member has documentation of tolerability and experienced a positive clinical response to 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:

PA 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.)