GI MOTILITY, CHRONIC AGENTS PRIOR AUTHORIZATION FORM (form effective 1/9/2023)

Prior authorization guidelines GI Motility, Chronic Agents and Quantity Limits/Daily Dose Limits are available on Geisinger Health Plan’s website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

<table>
<thead>
<tr>
<th>New request</th>
<th>Renewal request</th>
<th>Total pages:</th>
<th>Prescriber name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of office contact:</td>
<td>Specialty:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact’s phone number:</td>
<td>NPI:</td>
<td>State license #:</td>
<td></td>
</tr>
<tr>
<td>LTC facility contact/phone:</td>
<td>Street address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beneficiary name:</td>
<td>City/state/zip:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beneficiary ID#:</td>
<td>DOB:</td>
<td>Phone:</td>
<td>Fax:</td>
</tr>
</tbody>
</table>

**CLINICAL INFORMATION**

<table>
<thead>
<tr>
<th>Drug requested:</th>
<th>Strength:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose/directions:</td>
<td>Quantity:</td>
</tr>
<tr>
<td>Diagnosis (submit documentation):</td>
<td>Dx code (required):</td>
</tr>
</tbody>
</table>

Complete all sections that apply to the beneficiary and this request. **Check all that apply and submit documentation for each item.**

**INITIAL requests**

1. **For treatment of a CONSTIPATION-related diagnosis** (eg, opioid-induced constipation, IBS with constipation, chronic idiopathic constipation):
   - Tried and failed or has a contraindication or an intolerance to at least 2 of the following (check all that apply):
     - 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, sennosides)
   - For a non-preferred GI Motility, Chronic Agent for the treatment of constipation:
     - Tried and failed or has a contraindication or an intolerance to the preferred GI Motility, Chronic Agents for the treatment of constipation (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)

2. **For treatment of a DIARRHEA-related diagnosis** (eg, IBS with diarrhea):
   - Is prescribed the requested medication by or in consultation with a gastroenterologist (submit documentation of consultation, if applicable)
   - For Lotronex (alosetron) (check all that apply):
     - Has severe diarrhea-predominant IBS that includes at least one of the following:
Frequent and severe abdominal pain/discomfort
Frequent bowel urgency or fecal incontinence
Disability or restriction of daily activities due to IBS
Has chronic IBS symptoms generally lasting 6 months or longer
Had anatomic or biochemical abnormalities of the GI tract excluded
Has not responded adequately to conventional therapy

RENEWAL requests

Experienced a positive clinical response since starting the requested medication

For treatment of a diarrhea-related diagnosis (eg, IBS with diarrhea):
Is prescribed the requested medication by or in consultation with a gastroenterologist (submit documentation of consultation, if applicable)

Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:  Date:

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.