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United Healthcare Community Plan

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

GI Motility, Chronic

If the following information is not complete, correct, or legible, the SA process can be delayed.
Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Preferred Medication (must be tried and failed first): Amitiza®, Linzess®, lubiprostone, or Movantik®

Non-preferred Medications: alosetron , Lotronex®, Motegrity™, Relistor®, Symproic™, Trulance™, Viberzi™

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

Does the member have any of the following diagnoses? **Please check all that apply.**

- ☐ Chronic idiopathic constipation (CIC)
- ☐ Constipation predominant irritable bowel syndrome (IBS-C)
- ☐ Functional constipation (FC) in pediatric patients 6 to 17 years of age

  Does the prescriber attest that other causes of constipation have been ruled out?

  ☐ Yes ☐ No
- ☐ Severe diarrhea predominant irritable bowel syndrome (IBS-D)
- ☐ Opioid induced constipation in chronic **non**-cancer pain (OIC)
- ☐ Other: _____

Amitiza®/Linzess®/Trulance™:

Has the member had a treatment failure on at least **TWO** of the following classes?

- Osmotic Laxatives (i.e., lactulose, polyethylene glycol, sorbitol);
- Bulk Forming Laxatives (i.e., psyllium, fiber); **OR**
- Stimulant Laxatives (i.e., bisacodyl, senna).

☐ Yes ☐ No

Amitiza®/Movantik®/Relistor®/Symproic® (OIC only):

Has the member had treatment failure on both polyethylene glycol **AND** lactulose?

☐ Yes ☐ No

Alosetron/Lotronex®/Viberzi™:

Has the member had a treatment failure on at least **THREE** of the following classes?

- Bulk forming laxatives (i.e., psyllium, fiber);
- Antispasmodic agents (i.e., dicyclomine, hyoscyamine); **OR**
- Antidiarrheal agents (i.e., loperamide, diphenoxylate/atropine, codeine).

☐ Yes ☐ No

Motegrity™:

Has the member had a treatment failure on the following?

- ≥ 2 preferred traditional laxative therapy (e.g., polyethylene glycol, lactulose); **AND**
- ≥ 1 preferred newer products indicated for CIC (e.g., linaclotide, lubiprostone, plecanatide).

☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

List pharmaceutical agents attempted and outcome:

Medical Necessity (Provide clinical evidence that the preferred agent(s) will not provide adequate benefit):

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA call center: 1-800-310-6826