Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Gastrointestinal (GI) Motility Agents Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 1 year; Continuation- 1 year

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Gastrointestinal (GI) Motility Agents.** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Member Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

Gender: □ Male □ Female Weight (kg): _____

2 – Provider Information

Provider Name: _____ Specialty: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:
□Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5 – Clinical Criteria

Preferred agents: Amitiza, Linzess, Movantik, lubiprostone

Non-Preferred agents: alosetron, Lotronex, Motegrity, Relistor, Symproic, Trulance, Viberzi

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; If yes, list therapy and outcome;

_____

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; If yes, list therapy and outcome:

_____

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; If yes, list therapy and outcome: _____

7 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**