Aetna Better Health® of Virginia Request Form

GI Motility, Chronic

Fax back to 1-855-799-2553

If the following information is not complete, correct, or legible, the PA 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®, or Movantik®

Non-preferred Medications: alosetron, lubiprostone, 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:

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

____
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____
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____
____

____ ____________________

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.