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: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

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).

☐ 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).

☐ 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 PA process.
Submission of documentation does NOT guarantee coverage.