Chronic GI Motility Agents

Please fax this completed form to (866) 399-0929 OR mail to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No

2. If this request is for a continuation of therapy, is there documentation showing positive clinical benefit of one of the following (check all that apply):
   - ☐ A ≥30% reduction in average daily abdominal pain score compared to baseline
   - ☐ Documentation of ≥3 or more spontaneous bowel movements per week
   - ☐ Increase of ≥1 spontaneous bowel movement per week compared to baseline
   - ☐ Reduction in number of days per week with at least 1 stool that has a type 6 or 7 consistency according to the Bristol Stool Form Scale (BSFS) compared to baseline.

3. Indicate patient's diagnosis:
   - ☐ Irritable bowel syndrome with constipation (IBS-C)
   - ☐ Chronic idiopathic constipation (CIC)
   - ☐ Opioid-induced constipation (OIC) with chronic non-cancer pain
   - ☐ Severe diarrhea-prominent irritable bowel syndrome (IBS)
   - ☐ Irritable bowel syndrome with diarrhea (IBS-D)
   - ☐ Opioid-induced constipation in patients with advanced illness or pain caused by active cancer requiring opioid dosage escalation for palliative care
   - ☐ Other. Specify:

4. Does patient have history of a known or suspected GI obstruction? ☐ Yes ☐ No

5. Does the patient have a history of failure, contraindication or intolerance to ≥ 2 week trial of any of the following conventional therapies? (check all that apply)
   - ☐ Antibiotics (e.g. rifaximin)
   - ☐ Antidepressants (e.g. amitriptyline, nortriptyline)
   - ☐ Antidiarrheal (e.g. loperamide)
   - ☐ Antispasmodics (e.g. dicyclomine, hyoscyamine)
   - ☐ Bile acid sequestrants (e.g. cholestyramine, colestipol)
   - ☐ Bulk-forming laxative (e.g. psyllium)
   - ☐ Osmotic agents (e.g. lactulose, polyethylene glycol)
   - ☐ Stimulant laxative (e.g. sennoside)
   - ☐ Stool softener (e.g. docusate sodium)

For tegaserod (Zelnorm) answer the following:

6. Does the patient have a history of any of the following (check all that apply):
   - ☐ Abdominal adhesions
   - ☐ Angina
   - ☐ Myocardial Infarction
   - ☐ Gallbladder disease
   - ☐ Ischemic Colitis
   - ☐ Stroke
   - ☐ Transient Ischemic attack
   - ☐ Other forms of intestinal ischemia

7. What is the patients eGFR? mL/min

For diagnosis of irritable bowel syndrome with diarrhea (IBS-D) answer the following:

8. Does the patient have a history of any of the following (check all that apply):
   - ☐ Alcoholism or consumption of more than 3 alcoholic drinks daily
   - ☐ Biliary duct obstruction
   - ☐ Chronic or severe constipation
   - ☐ Severe hepatic impairment (child Pugh C)
   - ☐ Cholecystectomy
   - ☐ Pancreatitis
   - ☐ Sphincter of Oddi disease or dysfunction

For diagnosis of severe diarrhea-prominent irritable bowel syndrome (IBS) answer the following:

9. Does the patient have any of the following symptoms? (check all that apply)
   - ☐ Frequent and severe abdominal pain/discomfort
   - ☐ Frequent bowel urgency or fecal incontinence
   - ☐ Disability or restriction of daily activities due to IBS-D

10. Does the patient have a history of any of the following (check all that apply):
   - ☐ Crohn's disease or ulcerative colitis
   - ☐ Toxic megacolon
   - ☐ Ischemic colitis
   - ☐ Thrombophlebitis or hypercoagulable state
   - ☐ Diverticulitis
   - ☐ Gastrointestinal perforation or adhesions
   - ☐ Impaired intestinal circulation
   - ☐ Severe hepatic impairment

Provide the following required documentation:

- **Chart notes**
- **Continuation of therapy requests: Documentation of positive clinical benefit, including baseline measures**

Prescriber signature	Prescriber specialty	Date

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)