

Chronic GI Motility Agents

Please provide the information below, print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request.

Please FAX responses to: (800) 869-7791. Phone: (800) 213-5525, Option 1-2-2.

Date of Request			
Patient	Date of Birth	Molina Member ID#	
Pharmacy Name	Pharmacy NPI	Telephone Number	Fax Number
Prescriber	Prescriber NPI	Telephone Number	Fax Number
Medication and Strength			Qty/Days Supply
Directions for Use			
<p>1. Is this request for a continuation of existing therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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):</p> <ul style="list-style-type: none"> <input type="checkbox"/> A $\geq 30\%$ reduction in average daily abdominal pain score compared to baseline <input type="checkbox"/> Documentation of ≥ 3 or more spontaneous bowel movements per week <input type="checkbox"/> Increase of ≥ 1 spontaneous bowel movement per week compared to baseline <input type="checkbox"/> 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 <p>3. Indicate patient's diagnosis:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Irritable bowel syndrome with constipation (IBS-C) <input type="checkbox"/> Chronic idiopathic constipation (CIC) <input type="checkbox"/> Opioid-induced constipation (OIC) with chronic non-cancer pain <input type="checkbox"/> Severe diarrhea-prominent irritable bowel syndrome (IBS) <input type="checkbox"/> Irritable bowel syndrome with diarrhea (IBS-D) <input type="checkbox"/> Opioid-induced constipation in patients with advanced illness or pain caused by active cancer requiring opioid dosage escalation for palliative care <input type="checkbox"/> Other. Specify: _____ <p>4. Does patient have history of a known or suspected GI obstruction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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)</p> <ul style="list-style-type: none"> <li style="width: 50%;"><input type="checkbox"/> Antibiotics (e.g. rifaximin) <li style="width: 50%;"><input type="checkbox"/> Antidepressants (e.g. amitriptyline, nortriptyline) 			

- | | |
|---|--|
| <input type="checkbox"/> Antidiarrheal (e.g. loperamide) | <input type="checkbox"/> Antispasmodics
(e.g. dicyclomine, hyoscyamine) |
| <input type="checkbox"/> Bile acid sequestrants (e.g. cholestyramine, colestipol) | <input type="checkbox"/> Bulk-forming laxative (e.g. psyllium) |
| <input type="checkbox"/> Osmotic agents (e.g. lactulose, polyethylene glycol) | <input type="checkbox"/> Stimulant laxative (e.g. sennoside) |
| <input type="checkbox"/> 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):
- | | | |
|--|---|--|
| <input type="checkbox"/> Abdominal adhesions | <input type="checkbox"/> Angina | <input type="checkbox"/> Myocardial Infarction |
| <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Ischemic Colitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Transient Ischemic attack | <input type="checkbox"/> 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):
- | | |
|--|---|
| <input type="checkbox"/> Alcoholism or consumption of more than 3 alcoholic drinks daily | <input type="checkbox"/> Cholecystectomy |
| <input type="checkbox"/> Biliary duct obstruction | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Chronic or severe constipation | <input type="checkbox"/> Sphincter of Oddi disease or dysfunction |
| <input type="checkbox"/> Severe hepatic impairment (child Pugh C) | |

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):
- | | |
|--|--|
| <input type="checkbox"/> Crohn's disease or ulcerative colitis | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Toxic megacolon | <input type="checkbox"/> Gastrointestinal perforation or adhesions |
| <input type="checkbox"/> Ischemic colitis | <input type="checkbox"/> Impaired intestinal circulation |
| <input type="checkbox"/> Thrombophlebitis or hypercoagulable state | <input type="checkbox"/> 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
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