Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Prior Authorization (PA) Form
GI Motility, Chronic

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, Lotronex®, Motegrity™, Relistor®, Symproic™, Trulance™, Viberzi™

Drug Name/Form: ______________________________

Strength: ______________________________

Dosing Frequency: ______________________________

Length of Therapy: ______________________________

Quantity per Day: ______________________________

(Form continued on next page.)

HealthKeepers, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc. Anthem HealthKeepers Plus, offered by HealthKeepers, Inc., is a health plan that contracts with the Virginia Department of Medical Assistance Services to provide Commonwealth Coordinated Care Plus (CCC Plus) benefits to enrollees.
AVAPEC-2298-19 December 2019

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)

☐ 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:

____

____

____

____

____

DIAGNOSIS AND MEDICAL INFORMATION *(continued)*

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.

The completed form may be **FAXED TO 1-844-512-7020**.