AmeriHealth Caritas New Hampshire

Bowel Disorder Medications

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / _____

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information			
Prescriber last name:		Prescriber first name:	
Prescriber address:		Prescriber representative:	
NPI number:		Specialty:	
Phone #:	Fax #:		

Clinical history
1. Is the medication being prescribed for the treatment of chronic constipation? ☐ Yes ☐ No If yes, answer questions 5–9.
2. Is the medication being prescribed for the treatment of irritable bowel syndrome? ☐ Yes ☐ No If yes, go to question 7.
3. Is the medication being prescribed for opioid induced constipation? ☐ Yes ☐ No If yes, go to question 7. If no, please provide patient diagnosis for use of this medication:
4. Is the patient averaging less than three (3) spontaneous bowel movements per week?
5. Has the patient been experiencing constipation symptoms for at least three (3) months? ☐ Yes ☐ No
6. Has the patient failed a trial or past therapy with at least 60 ml/day of lactulose? (Describe below). ☐ Yes ☐ No
7. Has the patient failed a trial or past therapy with polyethylene glycol (MiraLAX®)? (Describe below). ☐ Yes ☐ No
8. Does the patient have a history of mechanical gastrointestinal obstruction? ☐ Yes ☐ No
9. Is the patient 18 years of age or older? ☐ Yes ☐ No
10. If female, is the patient pregnant? ☐ Yes ☐ No
Please describe treatment failures and provide dates:
Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

Signature of prescriber:_____ Date: _____
(prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.