COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

BOWEL DISORDER MEDICATIONS

If the following information is not complete, correct, or legible, the SA process can be delayed.
Please use one form per member.

PATIENT 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 1st): Amitiza® or Linzess®

Non-preferred Medications: alosetron, Lotronex®, Movantik®, Relistor®, Trulance™, Viberzi™

Drug Name/Form: ____

Strength: ____

Dosing Frequency: ____

Length of Therapy: ____

Quantity per Day: ____

(Form continued on next page.)

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Patient's Last Name: | | | | | | | | | | | | |

Patient's First Name: | | | | | | | | | | | | |

DIAGNOSIS AND MEDICAL INFORMATION

Does the patient have any of the following diagnoses? Please check all that apply:

☐ Idiopathic Chronic Constipation (ICC)

☐ 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 patient 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® (OIC only):

Has the patient had treatment failure on both polyethylene glycol **AND** lactulose?

☐ Yes ☐ No

Lotronex®/Viberzi™:

Has the patient 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

List Pharmaceutical agents attempted and outcome:

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(Form continued on next page.)

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Patient's Last Name: | | | | | | | | | | | | |

Patient's First Name: | | | | | | | | | | | | |

DIAGNOSIS AND MEDICAL INFORMATION *(continued)*

Medical Necessity: Provide clinical evidence that the preferred agent(s) will not provide adequate benefit.

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Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by patient records.

Please include ALL requested information; Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Magellan Medicaid Administration / ATTN: MAP
11013 W. Broad Street, Glen Allen, VA 23060

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