



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
 P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Gastrointestinal Agents — Antidiarrheals and Bowel Preparation Agents Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at www.mass.gov/druglist.

Member information

Last name _____ First name _____ MI _____
 MassHealth member ID # _____ Date of birth _____
 Gender (Check one.) F M Member's place of residence home nursing facility

Medication information

Medication requested

Antidiarrheals (See Sections I and II as applicable.)

- alosetron Motofen (difenoxin/atropine) Mytesi (crofelemer)
 opium tincture Viberzi (eluxadoline)

Bowel Preparation Agents (See Section III.)

- Clenpiq (sodium picosulfate/magnesium oxide/anhydrous citric acid)
 Plenvu (polyethylene glycol-electrolyte solution)
 Suprep (sodium sulfate/potassium sulfate/magnesium sulfate)

Dose and frequency of medication requested _____

Section I. Please complete for all Antidiarrheal Agent requests.

Diagnosis

- Chronic diarrhea Irritable bowel syndrome with diarrhea Diarrhea in an HIV/AIDS member
 Other _____

Previous Trials (check all that apply.)

Antidiarrheals

- bismuth subsalicylate
 diphenoxylate/atropine
 loperamide

Other

- Bile acid sequestrant
 Selective serotonin reuptake inhibitor
 Tricyclic antidepressant
 Other (please specify) _____

Did the member experience any of the following? Adverse reaction Inadequate response
 Briefly describe details of adverse reaction or inadequate response. _____

If the member has a contraindication to these trials please describe.

Section II. Please also complete for alosetron and Viberzi requests.

Is the prescriber a gastroenterologist? Yes No. Please attach consultation notes from a gastroenterologist addressing the use of the requested agent.

Please provide details for the previous trials.

Drug name _____ Dates/duration of use _____

Did the member experience any of the following? Adverse reaction Inadequate response

Briefly describe details of adverse reaction or inadequate response. _____

Drug name _____ Dates/duration of use _____

Did the member experience any of the following? Adverse reaction Inadequate response

Briefly describe details of adverse reaction or inadequate response. _____

Drug name _____ Dates/duration of use _____

Did the member experience any of the following? Adverse reaction Inadequate response

Briefly describe details of adverse reaction or inadequate response. _____

Section III. Please complete for Bowel Preparation Agent requests.

Has the member had a trial with a polyethylene glycol product that is available without prior authorization?

Yes. Please provide details for previous trial.

Drug name _____ Dates/duration of use _____

Did the member experience any of the following? Adverse reaction Inadequate response

Briefly describe details of adverse reaction or inadequate response. _____

No. Please explain why. _____

Section VI. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

* *Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____