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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)
☐ Suprep (sodium sulfate/potassium sulfate/magnesium sulfate)
☐ Sutab (sodium sulfate/magnesium sulfate/potassium chloride)

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 _____

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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 one bowel prep 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 IV. 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 _____