



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](http://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.

**Indication** (Check all that apply.)

- 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.

\_\_\_\_\_

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**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. \_\_\_\_\_

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**Section III. Please complete for Bowel Preparation Agent requests.**

1. Has the member had a trial with one bowel prep product that is available without prior authorization?

Yes. Please provide details for the 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. \_\_\_\_\_

2. Please also complete for Sutab requests. Has the member had a trial with Osmoprep, Plenvu, or polyethylene glycol-electrolyte solution [Moviprep]?

Yes. Please provide details for the 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. \_\_\_\_\_

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**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.

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\_\_\_\_\_

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**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

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**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 \_\_\_\_\_