**HEALTH PARTNERS PLANS**
***PRIOR AUTHORIZATION REQUEST FORM***

# GI Motility Agents - Chronic

**Phone: 215-991-4300** **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

| | | |
|---|---|---|
| Member Name: | Prescriber Name: | |
| HPP Member Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Member Primary Phone: | NPI: | *PA PROMISe ID:* |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Line of Business: ☐ Medicaid ☐ CHIP | *Specialty Pharmacy (if applicable):* | |
| **Drug Name:** | **Strength:** | |
| **Quantity:** | **Refills:** | |
| **Directions:** | | |
| **Diagnosis Code:** | **Diagnosis:** | |
| *HPP's maximum approval time is 12 months but may be less depending on the drug.* | | |

**Please attach any pertinent medical history including labs and information for this member that may support approval.**
***Please answer the following questions and sign.***

Q1. Is the patient prescribed a dose that is consistent with Food and Drug Administration (FDA) approved package
labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q2. Does the patient have a contraindication to the requested medication?

☐ Yes ☐ No

Q3. Is this a request for a drug indicated for the treatment of a diagnosis involving diarrhea?

☐ Yes ☐ No

Q4. Is the requested drug being prescribed by or in consultation with a gastroenterologist?

☐ Yes ☐ No

Q5. Is this a request for a renewal of authorization? [If no, then skip to question 7.]

☐ Yes ☐ No

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|---|---|

Q6. Does the patient have documentation of tolerability and a positive clinical response to the medication?

☐ Yes ☐ No

Q7. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA) approved
package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q8. Is the requested drug age-appropriate according to Food and Drug Administration (FDA) approved package
labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q9. Is the requested drug indicated for treatment of a diagnosis involving constipation [If no, skip to question 11]?

☐ Yes ☐ No

Q10. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of TWO of
the following: A) laxatives, B) fiber supplementation, C) osmotic agents, D) bulk forming agents, E) glycerin or
bisacodyl suppositories?

☐ Yes ☐ No

Q11. For an agent indicated for the treatment of a diagnosis involving diarrhea, does the patient have a documented
therapeutic failure of a low fermentable oligosaccharides, disaccharides, and monosaccharides and polyols (FODMAP)
diet?

☐ Yes ☐ No

Q12. Is this a request for a preferred chronic gastrointestinal (GI) motility agent?

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☐ Yes ☐ No

Q13. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred chronic gastrointestinal (GI) motility agents approved or medically accepted for the patient's diagnosis?

☐ Yes ☐ No

Q14. Additional Information:

Prescriber Signature

Date

*v2025*