

## Irritable Bowel Syndrome - Diarrhea Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.  
**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.**  
**Allow at least 24 hours for review.**

### Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

### Section B - Provider Information

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

### Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

### Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

### Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at [www.uhcprovider.com](http://www.uhcprovider.com) for a list of preferred alternatives

<b>Member First name:</b>	<b>Member Last name:</b>	<b>Member DOB:</b>
---------------------------	--------------------------	--------------------

**Clinical and Drug Specific Information**

**ALL REQUESTS**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have either of the following diagnoses?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Irritable bowel syndrome with diarrhea (IBS-D) <input type="checkbox"/> Severe diarrhea-predominant irritable bowel syndrome (IBS)
--	--

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a history of failure, contraindication, or intolerance to two of the following:</b> <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Antispasmodic agent [e.g., dicyclomine] <input type="checkbox"/> Antidiarrheal agents [e.g., loperamide] <input type="checkbox"/> Tricyclic antidepressant [e.g., amitriptyline]
--	--

**LOTROXEX (ALOSETRON)**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Was the patient female at birth?</b>
--	---

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Has the patient had symptoms for at least 6 months?</b>
--	--

**CONTINUATION OF THERAPY**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is there documentation of positive clinical response to therapy?</b> <i>If yes, list response:</i>
--	--

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Confidentiality Notice:** This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.