

HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM INTERSTITIAL CYSTITIS MEDICATIONS

Elmiron®, RIMSO-50®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Elmiron® (pentosane polysulfate sodium), ☐ RIMSO-50® (dimethyl sulfoxide)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Has the member been clinically diagnosed with interstitial cystitis or bladder pain syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member had urinary tract symptoms for more than 6 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide baseline voiding symptoms and pain levels
3. Does the member have a urinalysis or urine culture that rules out a urinary tract infection (UTI)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Have other identifiable causes been ruled out (e.g. overactive bladder, endometriosis and vulvodynia, and prostatitis)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Is the request made by, or in consultation with, a urologist?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Has the member participated in conservative treatments (e.g. stress management, pain management, and self-care/behavioral modification)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
7. Has the member had a trial and failure of, or intolerance/contraindication to, amitriptyline and/or cimetidine?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

RIMSO-50

1. Is the request for RIMSO-50®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has heparin or lidocaine been trialed?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

ELMIRON

1. Is the request for Elmiron®?	<input type="checkbox"/>	<input type="checkbox"/>	
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2. Has the member had a trial and failure or contraindication/intolerance to at least 2 intravesical agents (e.g. dimethyl sulfoxide, heparin, or lidocaine)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the medication shown efficacy, defined as improvement in baseline voiding symptoms and pain levels?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

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Policy: PHARM-CHIP-039
 Origination Date: 07/01/2024
 Reviewed/Revised Date: 11/13/2024
 Next Review Date: 11/13/2025
 Current Effective Date: 12/01/2024

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