HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM

IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D)

alosetron hydrochloride, Xifaxan®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U 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: ☐ alosetron hydrochloride, ☐ Xifaxan® (rifaximin)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Has the member been diagnosed with irritable bowel syndrome with diarrhea?	☐	☐	
2. Is the requesting provider a gastroenterologist?	☐	☐	
3. Has the member had a trial and failure of nutritional and/or behavioral therapy (e.g. lactose restriction, gluten-free, low carb, increased physical activity, etc.)?	☐	☐	**Please provide documentation**
4. Has the member had a trial and failure of, or contraindication to, at least one antidiarrheal (e.g. loperamide, diphenoxylate)?	☐	☐	**Please provide documentation**
5. Has the member had a trial and failure of, or contraindication to, at least one antispasmodic (e.g. dicyclomine, hyoscyamine)?	☐	☐	**Please provide documentation**
6. Has the member had a trial and failure of, or contraindication to, at least one tricyclic antidepressant (e.g. imipramine, desipramine)?	☐	☐	**Please provide documentation**
7. For alosetron hydrochloride: Does the member have any of the following: • History of chronic or severe constipation • History of intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation and/or adhesions • History of ischemic colitis, impaired intestinal circulation, ulcerative colitis, or Crohn's disease • Active diverticulitis or a history of diverticulitis	☐	☐	

• Concomitant use of fluvoxamine			
REAUTHORIZATION			
1. Is the request for reauthorization?	☐	☐	
2. Does updated clinical documentation show continued medical necessity and disease stabilization or improvement of disease?	☐	☐	**Please provide documentation**
3. Please note: rifampin will only be approved for a maximum of three 14-day courses.	☐	☐	
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-HU-034
Origination Date: 01/01/2022
Reviewed/Revised Date: 05/22/2024
Next Review Date: 05/22/2025
Current Effective Date: 06/01/2024