REALRx

Healthy U
Health Choice Utah

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 RealRx Medicaid 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 Pharmacy Customer Service for assistance.

- Healthy U Medicaid: 855-856-5694
- Health Choice Utah: 855-864-1404

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?	☐	☐	
2. Has the member had urinary tract symptoms for more than 6 weeks?	☐	☐	**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)?	☐	☐	**Please provide documentation**
4. Have other identifiable causes been ruled out (e.g. overactive bladder, endometriosis and vulvodynia, and prostatitis)?	☐	☐	**Please provide documentation**
5. Is the request made by, or in consultation with, a urologist?	☐	☐	
6. Has the member participated in conservative treatments (e.g. stress management, pain management, and self-care/behavioral modification)?	☐	☐	**Please provide documentation**
7. Has the member had a trial and failure of, or intolerance/contraindication to, amitriptyline and/or cimetidine?	☐	☐	**Please provide documentation**
RIMSO-50			
1. Is the request for RIMSO-50®?	☐	☐	
2. Has heparin or lidocaine been trialed?	☐	☐	**Please provide documentation**
ELMIRON			

1. Is the request for Elmiron®?	☐	☐	
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)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the medication shown efficacy, defined as improvement in baseline voiding symptoms and pain levels?	☐	☐	**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:

PRESCRIBER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Physician's Signature:	**Date:**

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Policy: PHARM-MM-039
Origination Date: 01/01/2022
Reviewed/Revised Date: 04/08/2026
Next Review Date: 04/08/2027
Current Effective Date: 05/01/2026

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