Prior Authorization Request Form for Lotronex (alosetron)

Member Information **Provider Information**

Patient Name _____ Provider Name _____

Cardholder ID _____ DEA Number _____

Date of Birth _____ Address _____

Address _____ City, State and Zip _____

City, State Zip _____ Phone Number _____

Phone Number _____ FAX Number _____

Pharmacy Information

Pharmacy Name_____Address_____Phone_____

FDA Approved Indications:

- The treatment of Irritable Bowel Syndrome (IBS) in women with severe diarrhea – predominant symptoms who have failed to respond to conventional therapy, whose symptoms are chronic (generally lasting longer than six months), and who have had other gastrointestinal medical conditions ruled out.
- The safety and effectiveness of Lotronex in men has not been established.

Criteria for Approval:

1. Is the patient 18 years of age or older? Yes ☐ No ☐
2. Is the patient female? Yes ☐ No ☐
3. Does the patient have a diagnosis of diarrhea-predominant chronic irritable bowel syndrome (IBS)? Yes ☐ No ☐
4. Has the physician excluded anatomical or biochemical abnormalities of the gastrointestinal tract (i.e., thyroid dysfunction, stool culture, colonoscopy, barium enema)? Yes ☐ No☐
5. Has the patient had continuous or recurrent symptoms of irritable bowel syndrome (IBS) for at least 6 months? Yes ☐ No ☐
6. Has the patient experienced therapeutic failure with any of the following? *Check all that apply:*
   ☐ Dicyclomine ☐ Hyoscyamine ☐ Loperamide ☐ Diphenoxylate/atropine
   ☐ Fiber supplement ☐ Other: _____
7. Does the patient have any of the following: *Check all that apply:*
   ☐ Diarrhea-prominent disease
   ☐ Frequent and severe abdominal pain and discomfort
   ☐ Frequent bowel urgency and/or fecal incontinence
   ☐ Disability or restriction of daily activities due to irritable bowel syndrome (IBS)
8. Does the patient have a history of any of the following? *Check all that apply:*
   ☐ Severe constipation or sequelae from constipation
   ☐ Intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, and/or adhesions
   ☐ Ischemic colitis, impaired intestinal circulation, thrombophlebitis, or hypercoagulable state
   ☐ Crohn's disease or ulcerative colitis
   ☐ ☐ Diverticulitis
9. Does the patient have any known hypersensitivity to any componenet of Lotronex? Yes ☐ No ☐
10. Has the physician counseled the patient about known risks versus benefits of using Lotronex to treat irritable bowel syndrome (IBS)? Yes ☐ No ☐
11. Will the patient be monitored for adverse events associated with using Lotronex (i.e., constipation or ischemic colitis)? Yes☐ No ☐
12. Is the physician enrolled in the Lotronex Prescribing Program? Yes ☐ No ☐
13. Has the patient received and completed the Lotronex Medication Guide? Yes ☐ No ☐
14. Have both the patient and physician signed the Patient-Physician Agreement? Yes ☐ No ☐
15. If the patient has received previous Lotronex therapy, has there been improvement of irritable bowel symptoms? Yes ☐ No ☐
16. Is this request for an increase in the dose of Lotronex? Yes ☐ No ☐
17. Does the patient require more than 2 tablets (2 mg) per day? Yes ☐ No ☐

Provider Signature _____Date_____

FOX Rx Care
We take your coverage personally.

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/Time Received_____

Reference Number_____

Approved / Denied (Circle One) by _____ Date_____

Date/Time Returned to Provider_____

If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284-4492 or FAX Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
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Tallahassee, FL 32308