FORM # FRX026

Prior Authorization Request Form for Zelnorm (tegaserod maleate)

Member Information

Patient Name ____________________________
Cardholder ID ___________________________
Date of Birth ____________________________
Address _________________________________
City, State Zip ___________________________
Phone Number ___________________________

Provider Information

Provider Name ______________________________
DEA Number ________________________________
Address ____________________________________
City, State and Zip ___________________________
Phone Number _______________________________
FAX Number ________________________________

Pharmacy Information

Pharmacy Name___________________Address__________________Phone_____________________

FDA Approved Indications:

- The short-term treatment of Irritable Bowel Syndrome (IBS) in women whose primary bowel symptom is constipation. The safety and effectiveness of Zelnorm in men for IBS has not been established.
- For the treatment of patients, male and female, less than 65 years of age with chronic idiopathic constipation. The effectiveness of Zelnorm in patients over 65 years of age with chronic idiopathic constipation 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 chronic irritable bowel syndrome (IBS)? Yes ☐ No ☐
4. Is constipation the primary symptom of the patient? Yes ☐ No ☐
5. Is the patient less than 65 years of age? Yes ☐ No ☐
6. Does the patient have a diagnosis of: *Check all that apply:*
   ☐ Chronic constipation ☐ Severe renal impairment ☐ Moderate to severe hepatic impairment
   ☐ Symptomatic gallbladder disease ☐ Suspected spincter of Oddi dysfunction
7. Does the patient have a history of: *Check all that apply:*
   ☐ Bowel obstruction ☐ Abdominal adhesions
8. Is the constipation due to other disease or drugs? Yes ☐ No ☐
9. Has the patient received Zelnorm therapy for: *Check one:*
   ☐ At least 4 weeks ☐ A total of 12 weeks
10. If the patient has received previous Zelnorm therapy, has there been improvement of irritable bowel symptoms? Yes ☐ No ☐

Provider Signature ____ Date ________________________

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/TimeReceived____
ReferenceNumber____
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
3375-I Capital Circle NE
Tallahassee, FL 32308

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