ProCare Rx

Lotronex® alosentron

Ticket #: _____ Request Date: _____ Request Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of Lotronex® alosentron. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information

Patient Name:	Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:

B. Physician Information

Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:

C. Pharmacy Information

Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information: circle all that apply)

1. Is patient a female at least 18 years of age? YES NO
2. Has the treating physician enrolled in GlaxoSmithKline Prescribing Program for Lotronex? YES NO
3. What is the patient's current diagnosis?
   - ☐ Severe diarrhea-predominant irritable bowel syndrome (IBS)
   - ☐ Other: _____
4. Does patient have any of the following: YES NO
   - ☐ Severe diarrhea*
   - ☐ Chronic IBS symptoms (generally lasting 6 months or longer)
   - ☐ Frequent and severe abdominal pain/discomfort
   - ☐ Frequent bowel urgency or fecal incontinence

   (*Severe diarrhea is defined as diarrhea and 1 or more of the following: frequent and severe abdominal pain/discomfort, frequent bowel urgency or fecal incontinence, disability or restriction of daily activities because of IBS.)
5. Have anatomic or biochemical abnormalities of the GI tract been excluded? YES NO
6. Has the patient failed to respond to conventional therapy? YES NO
7. Does patient have any of the following? YES NO
   - ☐ History of chronic or severe constipation or with a history of sequelae from constipation
   - ☐ History of intestinal obstruction, stricture, toxic megacolon, GI perforation, and/or adhesions
   - ☐ History of ischemic colitis, impaired intestinal circulation, thrombophlebitis, or hypercoagulable state
   - ☐ Current or a history of Crohn's disease or ulcerative colitis
   - ☐ Active diverticulitis or a history of diverticulitis

Dosing Recommendations: Starting dose, 0.5mg PO BID; maximum dose, 1mg PO BID.

Authorized Medical Signature:	
Telephone:	Date:

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.