Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

GI Motility Agents - Chronic

Phone: 866-841-7659 **Fax back to: 866-240-3712**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this an initial request or re-authorization request?

☐ Initial request ☐ Re-authorization request

Q2. What is the product being requested?

☐ GI Motility, Chronic Agents ☐ Other

Q3. If other, please specify:

Q4. Is the member prescribed the GI Motility, Chronic Agent for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q5. Is the member age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q6. Is the prescribed dose consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q7. Does the member have a contraindication to the prescribed medication?

☐ Yes ☐ No

Q8. Which of the following applies to the member?

☐ The request is for an agent indicated for treatment of a diagnosis involving constipation
☐ The request is for an agent indicated for treatment of a diagnosis involving diarrhea
☐ None of the above

Q9. For an agent indicated for treatment of a diagnosis involving constipation, does the member have a documented history of therapeutic failure of or a contraindication or an intolerance to two of the following?

☐ Laxatives
☐ Fiber supplementation
☐ Osmotic agents
☐ Bulk forming agents
☐ Glycerin or bisacodyl suppositories
☐ None of the above

Q10. For an agent indicated for treatment of a diagnosis involving diarrhea, is the medication prescribed by or in consultation with a gastroenterologist?

☐ Yes ☐ No

Q11. For a non-preferred GI Motility, Chronic Agent, does the member have a history of therapeutic failure of or a contraindication or an intolerance to the preferred GI Motility, Chronic Agents approved or medically accepted for the member's diagnosis?

☐ Yes ☐ No

Q12. Does the member have documentation of a positive clinical response to the medication?

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Member Name:	Prescriber Name:

☐ Yes	☐ No
Q13. Is the prescribed dose consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?	
☐ Yes	☐ No
Q14. Does the member have a contraindication to the prescribed medication?	
☐ Yes	☐ No
Q15. For an agent indicated for treatment of a diagnosis involving diarrhea, is the medication prescribed by or in consultation with a gastroenterologist?	
☐ Yes	☐ No
Q16. Additional Information:	

Prescriber Signature

Date

v2026-06