



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: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</i>			

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 the patient prescribed a dose that is consistent with Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q2. Does the patient have a contraindication to the requested medication?

Yes

No

Q3. Is this a request for a drug indicated for the treatment of a diagnosis involving diarrhea?

Yes

No

Q4. Is the requested drug being prescribed by or in consultation with a gastroenterologist?

Yes

No

Q5. Is this a request for a renewal of authorization? [If no, then skip to question 7.]

Yes

No



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Q6. Does the patient have documentation of tolerability and a positive clinical response to the medication?

Yes

No

Q7. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package labeling OR a medically accepted indication?

Yes

No

Q8. Is the requested drug age-appropriate according to Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q9. Is the requested drug indicated for treatment of a diagnosis involving constipation [If no, skip to question 11]?

Yes

No

Q10. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of TWO of the following: A) laxatives, B) fiber supplementation, C) osmotic agents, D) bulk forming agents, E) glycerin or bisacodyl suppositories?

Yes

No

Q11. For an agent indicated for the treatment of a diagnosis involving diarrhea, does the patient have a documented therapeutic failure of a low fermentable oligosaccharides, disaccharides, and monosaccharides and polyols (FODMAP) diet?

Yes

No

Q12. Is this a request for a preferred chronic gastrointestinal (GI) motility agent?



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Yes

No

Q13. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred chronic gastrointestinal (GI) motility agents approved or medically accepted for the patient's diagnosis?

Yes

No

Q14. Additional Information:

Prescriber Signature

Date

v2026-06