



# New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Bowel Disorder Medications

DATE OF MEDICATION REQUEST:     /     /

## SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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MEDICAID ID NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

GENDER:  Male  Female

Drug Name

FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

DATE OF BIRTH:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Strength

Dosing Directions

Length of Therapy

## SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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SPECIALTY:

FIRST NAME:

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NPI NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

PHONE NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

FAX NUMBER:

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## SECTION III: CLINICAL HISTORY

- Is the medication being prescribed for the treatment of chronic constipation? If yes, go to question 5.  Yes  No
- Is the medication being prescribed for the treatment of irritable bowel syndrome? If yes, go to question 7.  Yes  No
- Is the medication being prescribed for opioid induced constipation? If yes, go to question 7.  Yes  No
- If no, please provide patient diagnosis for use of this medication: \_\_\_\_\_
- Is the patient averaging less than three (3) spontaneous bowel movements per week?  Yes  No
- Has the patient been experiencing constipation symptoms for at least three (3) months?  Yes  No
- Has the patient failed a trial or past therapy with at least 60ml/day of lactulose? (describe below)  Yes  No
- Has the patient failed a trial or past therapy with polyethylene glycol (Miralax®)? (describe below)  Yes  No
- Does the patient have a history of mechanical gastrointestinal obstruction?  Yes  No
- Is the patient 18 years of age or older?  Yes  No
- If female, is the patient pregnant?  Yes  No

Please describe treatment failures and provide dates:

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Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

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I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_