Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
IBS-C, CIC Agents (Trulance, Linzess) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **IBS-C, CIC Agents (Trulance, Linzess).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Prescribed by a Gastroenterologist or in consultation with a Gastroenterologist,
   □ No □ Yes

2. **AND** member has a diagnosis of irritable bowel syndrome (IBS-constipation predominant)
   □ No □ Yes

3. **AND** member has had an inadequate response to an adequate trial of at least 4 weeks or intolerance or contraindication to scheduled doses of the following medications:
   - Fiber supplement: psyllium fiber or methylcellulose
   - Polyethylene glycol
   - Amitiza (lubiprostone) - if patient is female
   - Trulance (plecanatide) – if order is for Linzess

   □ No □ Yes

OR

1. Prescribed by a Gastroenterologist or in consultation with a Gastroenterologist,
   □ No □ Yes

2. **AND** member has a diagnosis of chronic idiopathic constipation,
   □ No □ Yes

3. **AND** member has had an inadequate response to an adequate trial of at least 4 weeks or intolerance or contraindication to scheduled doses of the following medications:
   - Fiber supplement: psyllium fiber or methylcellulose
   - Osmotic laxative: polyethylene glycol or lactulose
   - Stimulant laxative: senna or bisacodyl
   - Amitiza (lubiprostone)
   - Trulance (plecanatide) – if order is for Linzess

   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Member has a positive clinical response to therapy
   □ No □ Yes

7 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**