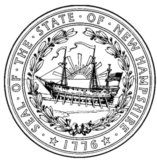

New Hampshire AIDS Drug Assistance Program
Prior Authorization Drug Approval Form

Bowel Disorder Medications

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

1. Is the medication being prescribed for the treatment of chronic constipation? ☐ Yes ☐ No
   *If **yes**, answer questions 5–9.*
2. Is the medication being prescribed for the treatment of irritable bowel syndrome? ☐ Yes ☐ No
   *If **yes**, go to question 7.*
3. Is the medication being prescribed for opioid-induced constipation? ☐ Yes ☐ No
   *If **yes**, go to question 7.*
   *If **no**, please provide patient diagnosis for use of this medication:* ____________
4. Is the patient averaging less than three spontaneous bowel movements per week? ☐ Yes ☐ No
5. Has the patient been experiencing constipation symptoms for at least three months? ☐ Yes ☐ No

(Form continued on next page.)

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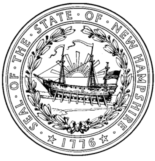

New Hampshire AIDS Drug Assistance Program
Prior Authorization Drug Approval Form

Bowel Disorder Medications

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY

6. Has the patient failed a trial or past therapy with at least 60 mL/day of lactulose? (**Describe below in field 12**). ☐ Yes ☐ No
7. Has the patient failed a trial or past therapy with polyethylene glycol (MiraLAX®)? (**Describe below in field 12**). ☐ Yes ☐ No
8. Does the patient have a history of mechanical gastrointestinal obstruction? ☐ Yes ☐ No
9. Is the patient 18 years of age or older? ☐ Yes ☐ No
10. Is the patient pregnant? ☐ Yes ☐ No
11. Please describe treatment failure(s) and provide dates:

____

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

____

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**: ____________________

Phone: 1-800-424-7901
Fax: 1-800-424-7984

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Magellan Rx MANAGEMENT℠