Lotronex® (alosetron) Prior Authorization Form

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Complete Patient and Physician information (PLEASE PRINT)

STEP 1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI Number:

If Applicable: Pharmacy Name: ______________________________
Pharmacy Phone: ______________________________

Complete the Clinical Assessment:

STEP 2

Diagnosis	☐ Irritable bowel syndrome, severe diarrhea-predominant	☐ Other (please state):
Clinical Consideration	Patient has had documented failure of at least one prior therapy (medication/date):	
	Is the patient female? ☐ Yes ☐ No	
Physician Specialty	Diagnosis made by: ☐ Gastroenterologist ☐ Prescriber experienced with Lotronex (state specialty):	
	Is the prescriber aware of the risks associated with Lotronex and signed up with the Prometheus REMS program? ☐ Yes ☐ No	
Supporting Documentation	Diagnosis: ICD-9/10 Code #/ Description / J Code (required):	
	Starting dose: 0.5 mg orally twice a day; after 4 weeks, may increase to 1 mg twice a day; only increase dosage if well tolerated and 0.5 mg twice a day dosing does not adequately control symptoms; discontinue in patients who have not demonstrated adequate control of IBS symptoms after 4 weeks of treatment with 1 mg twice a day.	
	Please attach a copy of the prescription or provide ALL of the information below: Lotronex® (alosetron) Strength ______________ Sig ______________ Qty ______________ Refills	
	Please attach all relevant medical records and test results **We will not process incomplete forms.** **If we do not receive the completed form & all relevant medical records & test results within 10 calendar days of this request, it will be denied.**	

STEP 3

I certify that the above is correct and accurate to the best of my knowledge and that the form is complete. (please sign and date)

______________________ ______________________
Prescriber Signature Date

STEP 4

Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk: 970-248-5034

Name of Person filling out form: ______________________________

Pharmacy Technician initials _______ Date Initiated ______________________

Confidentiality Notice:

This facsimile transmission (and/or documents accompanying it) may contain confidential information. This information is intended only for the use of the individual(s) named above. If you have received this transmission in error, or cannot identify the recipient for distribution purposes, please notify us immediately at 970-244-7760. Plans underwritten by Rocky Mountain HMO or Rocky Mountain HealthCare Options. **09/14/10**