

Ticket #: \_\_\_\_\_ Request Date: \_\_\_\_\_ Request Time: \_\_\_\_\_

**PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM**

A request for the patient identified below has been made for the dispensing of **Lotronex®** alosentron. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information			
Patient Name:		Plan Name/Plan ID:	
Patient ID:		Patient Date of Birth:	Patient Contact Phone #:
B. Physician Information			
Physician Name:		Physician Address:	
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:
C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:
D. Clinical Information (Please fill out the following information: circle all that apply)			
1. Is patient a female at least 18 years of age?		YES	NO
2. Has the treating physician enrolled in GlaxoSmithKline Prescribing Program for Lotronex?		YES	NO
3. What is the patient's current diagnosis?			
<input type="checkbox"/> Severe diarrhea-predominant irritable bowel syndrome (IBS) <input type="checkbox"/> Other: _____			
4. Does patient have any of the following:		YES	NO
<input type="checkbox"/> Severe diarrhea* <input type="checkbox"/> Chronic IBS symptoms (generally lasting 6 months or longer) <input type="checkbox"/> Frequent and severe abdominal pain/discomfort <input type="checkbox"/> Frequent bowel urgency or fecal incontinence <small>(*Severe diarrhea is defined as diarrhea and 1 or more of the following: frequent and severe abdominal pain/discomfort, frequent bowel urgency or fecal incontinence, disability or restriction of daily activities because of IBS.)</small>			
5. Have anatomic or biochemical abnormalities of the GI tract been excluded?		YES	NO
6. Has the patient failed to respond to conventional therapy?		YES	NO
7. Does patient have any of the following?		YES	NO
<input type="checkbox"/> History of chronic or severe constipation or with a history of sequelae from constipation <input type="checkbox"/> History of intestinal obstruction, stricture, toxic megacolon, GI perforation, and/or adhesions <input type="checkbox"/> History of ischemic colitis, impaired intestinal circulation, thrombophlebitis, or hypercoagulable state <input type="checkbox"/> Current or a history of Crohn's disease or ulcerative colitis <input type="checkbox"/> Active diverticulitis or a history of diverticulitis			
Dosing Recommendations: Starting dose, 0.5mg PO BID; maximum dose, 1mg PO BID.			
Authorized Medical Signature:			
Telephone:		Date:	

**When Completed Return To:**

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507  
1-866-965-Drug (3784) / Fax # 866-999-7736

\*\*Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.