



PA16 - CHRONIC IDIOPATHIC CONSTIPATION
NOT required for recipients less than 21 years of age.

Executive Office of Health & Human Services
PRIOR AUTHORIZATION REQUEST FORM for RI MEDICAID FEE FOR SERVICE (FFS)
Hewlett Packard Enterprise ATTN: PHARMACIST
301 Metro Center Blvd., 3rd Floor • Warwick, RI 02886 • FAX (401) 784-3889

CLIENT NAME: _____ DOB: ____ / ____ / ____ MEDICAID ID NUMBER: _____

PRESCRIBER NAME: _____ PRESCRIBER NPI #: _____

PRESCRIBER OFFICE ADDRESS: _____

OFFICE PHONE NUMBER () _____ FAX NUMBER () _____

DRUG REQUESTED: _____ QTY / FILL _____

DOES THE PATIENT HAVE AT LEAST TWO CONSTIPATION ICD-10'S SUBMITTED FROM 3 MONTHS TO 2 YEARS AGO IN ADDITION TO AT LEAST ONE ICD-10 SUBMITTED IN THE LAST 3 MONTHS? YES / NO

DOES THE PATIENT HAVE AT LEAST 1 CLAIM FOR A PRESCRIPTION LAXATIVE IN THE LAST 6 MONTHS? YES / NO

HAS THE PATIENT TRIED AND FAILED AT LEAST 2 DIFFERENT LAXATIVES (STIMULANTS OR FIBER LAXATIVES)? YES / NO

COMMENTS:

PRESCRIBER SIGNATURE _____ DATE _____

BY SIGNATURE, THE PRESCRIBER CONFIRMS THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

CONTACT HEWLETT PACKARD ENTERPRISE CUSTOMER SERVICE FOR QUESTIONS 1-401-784-8100

FOR STATE USE ONLY:

APPROVAL: ____ YES ____ NO PRIOR AUTHORIZATION #: _____

EFFECTIVE DATES: FROM: _____ TO _____