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)
Gainwell Technologies 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 LAS T 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 GAINWELL TECHNOLOGIES CUSTOMER SERVICE FOR QUESTIONS 1-401-784-8100

FOR STATE USE ONLY:

APPROVAL: _____YES _____NO PRIOR AUTHORIZATION #: ______________

EFFECTIVE DATES: FROM: ______________ TO ______________