Prescriber Criteria Form

Lotronex 2025 PA Fax 1435-A v1 010125.docx
Lotronex (alosetron)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Lotronex (alosetron).

Drug Name:
Lotronex (alosetron)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for a biological female or a person that self-identifies as a female with a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS)? [If no, then no further questions.]	Yes ◯	No ◯
2	Has the patient experienced chronic irritable bowel syndrome (IBS) symptoms lasting at least 6 months? [If no, then no further questions.]	Yes ◯	No ◯
3	Have gastrointestinal tract abnormalities been ruled out? [If no, then no further questions.]	Yes ◯	No ◯
4	Has the patient experienced an inadequate treatment response to one conventional therapy (e.g., antispasmodics, antidepressants, antidiarrheals)?	Yes ◯	No ◯

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date:_____