

LOTRONEX

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

| Patient Information | |
|---------------------|-----------------|
| Name: | Insurance ID #: |
| Address: | Birthdate: |

| Provider Information | |
|----------------------|------------------|
| Physician's Name: | Physician DEA #: |
| Phone: | Fax: |
| Office Address: | |
| Diagnosis: | ICD-9 Code: |

When this form is complete, please fax to Caremark at 888-836-0730.

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

1. Has the patient received at least four weeks of continuous Lotronex therapy through a benefit administered by CVS Caremark within the last 30 days for the diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS)?
[If the answer to this question is no, skip to question 5.] Y N
2. Has the patient had an improvement of irritable bowel symptoms since initiating Lotronex?
[If the answer to this question is yes, skip to question 4.] Y N
3. Is the request for an increase in the dose of Lotronex? Y N
4. Does the patient require more than two tablets (2mg) per day?
[No further questions are required.] Y N
5. Is the patient 18 years old or older? Y N
6. Is the patient female? Y N
7. Does the patient have the diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS)? Y N
8. Have other anatomical or biochemical abnormalities of the gastrointestinal tract been excluded as a cause of the symptoms to be treated by Lotronex? Y N

LOTRONEX

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

9. Has the patient had continuous or recurrent irritable bowel symptoms for at least six months? Y N
10. Does the patient have frequent and severe abdominal pain and discomfort?
[If the answer to this question is yes, skip to question 13.] Y N
11. Does the patient have frequent bowel urgency or fecal incontinence?
[If the answer to this question is yes, skip to question 13.] Y N
12. Does the patient have disability or restriction of daily activities due to IBS? Y N
13. Has the patient responded to conventional therapy for the treatment of irritable bowel syndrome? Y N
14. Does the patient have a history of any of the following that are contraindicated with Lotronex therapy?
- Chronic or severe constipation or sequelae from constipation
 - Intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation and/or adhesions Y N
 - Ischemic colitis, impaired intestinal circulation, thrombophlebitis or hypercoagulable state
 - Crohn's disease or ulcerative colitis
 - Diverticulitis
 - Severe hepatic impairment
15. Will the Lotronex-related adverse events be monitored? Y N

Comments: _____

Information on this form is accurate as of the date below.

| | |
|--------------------------------|--------------|
| Prescriber's Signature: | Date: |
|--------------------------------|--------------|