Louisiana Medicaid
Chronic GI Motility Agents

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request prior authorization for non-preferred chronic GI motility agents.

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation ~~and Continuation~~ of Therapy

- There is no preferred alternative that is the exact same chemical entity, formulation, strength, and delivery device; **AND**
- The recipient has a diagnosis approved for the medication requested (see POS Edits); **AND**
- Previous use of a preferred product* - the following is required:
  - The recipient has tried at least **TWO** preferred products that resulted in:
    - a *treatment failure*; **OR**
    - an *intolerable side effect*; **OR**
  - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated.~~; **OR**~~
  - ~~The prescriber **states on the request** that the recipient is currently using the requested medication **AND ONE** of the following applies:~~
    - ~~There is evidence in pharmacy claims of at least 60 days of the requested medication within the previous 90-day period; **OR**~~
    - ~~There is evidence in pharmacy claims of less than 60 days of the requested medication **AND** the prescriber states the recipient has been treated with the requested medication in an inpatient facility; **OR**~~
    - ~~There is evidence in pharmacy claims of less than 60 days of the requested medication **AND** the prescriber has verified that the pharmacy has dispensed at least 60 days of medication (billed to other insurance, and therefore not viewable in pharmacy claims).~~

**NOTE: Some therapeutic classes may only have one preferred product. Some may only have one preferred product that is appropriate for the condition being treated. The recipient may have documented contraindications to all but one preferred product. In these or similar cases, failure with only one preferred product is sufficient to meet this criterion.*

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is currently established on the medication with evidence of a positive response to therapy.

Duration of approval for initiation and continuation of therapy: **12 months**

References

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; https://www.clinicalkey.com/pharmacology/

DiPiro JT, Talbert RL, Yee GC, Matzke GR, Wells BG, Posey L. eds. Pharmacotherapy: A Pathophysiologic Approach, 10e New York, NY: McGraw-Hill; https://accesspharmacy.mhmedical.com/book.aspx?bookid=1861

Revision / Date	**Implementation Date**
Single PDL Implementation	May 2019
Separated "Select Therapeutic Classes with Established Recent Claims" into individual therapeutic class documents / November 2019	January 2020
Added specific wording for use of Amitiza®, formatting changes, updated references / April 2021	July 2021
Removed specific wording for use of Amitiza®, formatting changes / April 2024	July 2024
Modified non-preferred criteria to require a trial and failure of two preferred agents / August 2024	January 2025
Created separate 'Continuation of Therapy' criteria, added diagnosis requirement / March 2025	August 2025