

Prescriber Criteria Form
Lotronex 2026 PA Fax 1435-A v1 010126.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: _____

Prescriber (or Authorized) Signature: _____ **Date:** _____

