Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

# Erythromycin Ethylsuccinate Oral Suspension Prior Authorization Request Form

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

| **Member Information** (required) | | | **Provider Information** (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | | Specialty: |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

## Medication Information (required)

| Medication Name: | Strength: | Dosage Form: |
|---|---|---|
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis below:**

❑ Gastroparesis

❑ Other diagnosis: ______________________________ ICD-10 Code(s): ______________________________

**Gastroparesis:**

Has the patient had an unsuccessful 30 day trial of metoclopramide? ❑ **Yes** ❑ **No**

*Chart notes must be submitted for documentation*

Does the patient have a potential for tachyphylaxis? ❑ **Yes** ❑ **No**

**Reauthorization, also answer the following:**

Does the patient have a positive response to 30 day trial of erythromycin suspension and medical necessity for continuation of therapy? ❑ **Yes** ❑ **No**

*Chart notes MUST be submitted*

**All other diagnoses:**

What is the requested length of therapy for the patient? ___________________________

Is the patient unable to swallow tablets? ❑ **Yes** ❑ **No**

*Chart notes must be submitted to document clinically significant contraindication to use of erythromycin tablets, such as radiation therapy of head/neck*

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

***Previous therapies will be verified through pharmacy paid claims or submitted chart notes.***

**Prescriber Signature:** ______________________________ **Date:** ______________________________

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_______________________________________________________________________________

_______________________________________________________________________________

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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