HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
INTERSTITIAL CYSTITIS MEDICATIONS
BOTOX®, Elmiron®, heparain, lidocaine, RIMSO-50®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Botox® (botulinum toxin A), ☐ Elmiron® (pentosane polysulfate sodium), ☐ heparin, ☐ lidocaine, ☐ RIMSO-50® (dimethyl sulfoxide)

Dosing/Frequency:____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request for Interstitial Cystitis (IC) or Bladder Pain Syndrome (BPS)?	☐	☐	
2. Has the member been clinically diagnosed with interstitial cystitis or bladder pain syndrome?	☐	☐	
3. Has the member had urinary tract symptoms for more than 6 weeks?	☐	☐	**Please provide baseline voiding symptoms and pain levels**
4. Does the member have a negative urinalysis or culture?	☐	☐	**Please provide documentation**
5. Have other identifiable causes been ruled out (e.g. overactive bladder, endometriosis and vulvodynia, and prostatitis)?	☐	☐	**Please provide documentation**
6. Is the requesting provider a urologist or in consultation with a urologist?	☐	☐	
7. Has the member participated in conservative treatments (e.g. stress management, pain management, and self-care/behavioral modification)?	☐	☐	**Please provide documentation**
8. Has the member had a trial and failure of, or intolerance/contraindication to, amitriptyline and/or cimetidine?	☐	☐	**Please provide documentation**
BOTOX®			

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1. Is the request for Botox®?	☐	☐	
2. Has the member had a trial and failure of, or intolerance to, ≥2 intravesical agents (e.g. dimethyl sulfoxide, heparin, or lidocaine)?	☐	☐	**Please provide documentation**
3. Is the member 18 years of age or older?	☐	☐	
RIMSO-50			
1. Is the request for RIMSO-50?	☐	☐	
2. Has heparin or lidocaine been trialed?	☐	☐	**Please provide documentation**
3. If requesting RIMSO-50, is the member 18 years of age or older?	☐	☐	
ELMIRON			
1. Is the request for Elmiron?	☐	☐	
2. Has the member had a trial and failure of, or intolerance to, ≥2 intravesical agents (e.g. dimethyl sulfoxide, heparin, or lidocaine)?	☐	☐	**Please provide documentation**
3. Is the member 16 years of age or older?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the medication shown efficacy, defined as improvement in baseline voiding symptoms and pain levels?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM- 039
Origination Date: 09/05/2018
Reviewed/Revised Date: 01/22/2020
Next Review Date: 01/23/2021
Current Effective Date: 01/22/2020

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