Date ______________________

Client ____________________

PRIOR AUTHORIZATION QUESTIONNAIRE - Lotronex® (alosetron)

M.D. Last Name: ____________________________ ***M.D. First Name:*** ____________________________

Physician Phone: ____________________________ ***Physician Fax:*** ____________________________

Patient ______________________________ ***ID#*** ______________________ ***DOB*** ______________

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. Does the patient have a diagnosis of severe diarrhea-prominent chronic irritable bowel syndrome (IBS)? Yes No
2. Has the patient had continuous or recurrent symptoms of IBS for at least 6 months? Yes No
3. Has the physician excluded anatomical or biochemical abnormalities of the gastrointestinal tract? Yes No
4. Has the patient tried/failed at least one antidiarrheal agent? Yes No

   If yes, please indicate past treatment(s) and dates of therapy ____
5. Does the patient currently have constipation? Yes No
6. Is the patient currently taking fluvoxamine? Yes No
7. Does the patient have a history of any of the following? (Check all that apply)
   - Severe constipation or sequelae from constipation
   - Intestinal obstruction, stricture, toxic megacolon, gastrointestinal performation, and/or adhesions
   - Ischemic colitis, impaired intestinal circulation, thrombophlebitis, or hypercoagulable state
   - Crohn’s diease or ulcerative colitis
   - Diverticulitis
   - Severe hepatic impairment
8. Has the physician counseled the patient about known risks versus benefits of using Lotronex to treat IBS? Yes No
9. Will the patient be monitored for adverse events associated with using Lotronex? Yes No
10. Is the physician enrolled in the Lotronex Prescribing Program? Yes No
11. Has the patient received and completed the Lotronex Medication Guide? Yes No
12. Have both the patient and physician signed the Patient-Physician Agreement? Yes No
13. Strength Requested: ______________________ SIG: ____

Physician Signature or name of person providing answers ____

Physician Comments ____

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Send or Fax completed form to:

877-329-7279

RESTAT
P.O. BOX 758
WEST BEND, WI 53095

www.restat.com

QUESTIONS PLEASE CALL:

877-526-9906