



Oral Constipation Agents Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to Prior Authorization of Benefits Center at 844-512-9004 or Provider Help Desk at 800-454-3730.

1. Patient information

2. Physician information

Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication

4. Strength

5. Directions

6. Quantity per 30 days

_____	_____	_____	Specify: _____
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7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for oral constipation agents subject to clinical criteria. **Payment for nonpreferred oral constipation agents will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred oral constipation agent.** Payment will be considered under the following conditions:

1. Patient meets the FDA approved age; and
2. Patient must have documentation of adequate trials and therapy failures with both of the following:
 - Stimulant laxative (senna) plus saline laxative (milk of magnesia); and
 - Stimulant laxative (senna) plus osmotic laxative (polyethylene glycol or lactulose).
3. Patient does not have a known or suspected mechanical gastrointestinal obstruction.

If the criteria for coverage are met, initial authorization will be given for 12 weeks to assess the response to treatment. Requests for continuation therapy may be provided if the prescriber documents adequate response to treatment.

Preferred

- Amitiza Linzess 145 mcg and 290 mcg Movantik

<https://providers.amerigroup.com/IA>

Nonpreferred

Linzess 72 mcg Lubiprostone Motegrity Relistor Symproic Trulance

Treatment failures:

Trial 1: Stimulant laxative (senna) plus osmotic laxative (polyethylene glycol/lactulose)

Stimulant laxative trial: _____

Name/dose: _____ Trial dates: _____

Failure reason: _____

Osmotic laxative trial: _____

Name/dose: _____ Trial dates: _____

Failure reason: _____

Trial 2: Stimulant laxative (senna) plus saline laxative (milk of magnesia)

Stimulant laxative trial: _____

Name/dose: _____ Trial dates: _____

Failure reason: _____

Saline laxative trial: _____

Name/dose: _____ Trial dates: _____

Failure reason: _____

Does patient have a known or suspected mechanical gastrointestinal obstruction: Yes No

Chronic idiopathic constipation (Amitiza, Linzess, Motegrity or Trulance)

Patient has less than 3 spontaneous bowel movements (SBMs) per week: Yes No

Patient has 2 or more of the following symptoms within the last 3 months:

Straining during at least 25% of the bowel movements

Lumpy or hard stools for at 25% of the bowel movements

Sensation of incomplete evacuation for at least 25% of the bowel movements

Documentation the patient is not currently not taking constipation causing therapies:

Medication review completed: Yes No

Current constipation therapies:

Yes, please list: No

Irritable bowel syndrome with constipation (Amitiza, Linzess or Trulance)

Patient is female (Amitiza requests only) Yes No

Patient has recurrent abdominal pain on average at least 1 day per week in the last 3 months associated with two or more of the following:

- Related to defecation
- Associated with a change in stool frequency
- Associated with a change in stool form

Opioid-induced constipation with chronic, noncancer pain: (Amitiza, Movantik, Relistor or Symproic)

Patient has been receiving stable opioid therapy for at least 30 days as seen in the patient's pharmacy claims

Yes No

Patient has less than 3 spontaneous bowel movements (SBMs) per week, with at least 25% associated with one or more of the following:

- Hard to very hard stool consistency
- Moderate to very severe straining
- Sensation of incomplete evacuation

Other diagnosis: _____

Renewal requests: Provide documentation of adequate response to treatment: _____

Requests for nonpreferred oral constipation agent: Document trial of preferred agent.

Drug name/dose: _____ Trial dates: _____

Failure reason: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

9. Physician signature

Prescriber or authorized signature

Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Important note: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*