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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 1-844-512-9004 or Provider Help Desk at 1-800-454-3730.

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: ______

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
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)
   - 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	**Nonpreferred**
☐ Amitiza	☐ Linzess 72mcg
☐ Linzess 145mcg and 290mcg	☐ Motegrity
☐ Movantik	☐ 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

☐ I**rritable 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 2 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 per week, with at least 25% associated with 1 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.