HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM

CONSTIPATION MEDICATIONS

Amitiza®, Linzess®, Motegrity™, Movantik®, Relistor®, Symproic®, Trulance®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

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.

Preferred: ☐ Linzess® (linaclotide), ☐ Movantik® (naloxegol)
Non-preferred: ☐ Amitiza® (lubiprostone), ☐ Motegrity™ (prucalopride), ☐ Relistor® (methylnaltrexone), ☐ Symproic® (naldemedine), ☐ Trulance® (plecanatide)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
CHRONIC IDIOPATHIC CONSTIPATION			
1. Is the request for Linzess®?	☐	☐	
2. If the request is for Amitiza®, Motegritiy® or Trulance®, has the member had an adequate trial and failure of Linzess®?	☐	☐	**Please provide documentation**
3. Has the member been diagnosed with Chronic Idiopathic Constipation?	☐	☐	**Please provide documentation**
4. Has the member had a trial and failure of a laxative such as lactulose or polyethylene glycol?	☐	☐	**Please provide documentation**
IRRITABLE BOWEL SYNDROME WITH CONSTIPATION			
1. Is the request for Linzess®?	☐	☐	
2. If the request is for Amitiza® or Trulance®, has the member had an adequate trial and failure with Linzess®?	☐	☐	**Please provide documentation**
3. Has the member been diagnosed with Irritable Bowel Syndrome with constipation?	☐	☐	**Please provide documentation**
4. Has the member had a trial and failure of a laxative such as lactulose or polyethylene glycol?	☐	☐	**Please provide documentation**
5. If the request is for Amitiza, is the member female?	☐	☐	

OPIOID INDUCED CONSTIPATION			
1. Is the request for Movantik®?	☐	☐	
2. If the request is for Amitiza® or Symproic®, has the member had an adequate trial and failure of Movantik®?	☐	☐	**Please provide documentation**
3. Has the member been diagnosed with opioid induced constipation?	☐	☐	**Please provide documentation**
4. Has the member had a trial and failure of a laxative such as lactulose or polyethylene glycol?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Has the therapy shown to be effective with an improvement in the member's condition?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**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 Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HU-017
Origination Date: 01/01/2022
Reviewed/Revised Date: 01/18/2023
Next Review Date: 01/18/2024
Current Effective Date: 02/01/2023