FAX Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
ORAL CONSTIPATION AGENTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for oral constipation agents subject to clinical criteria. Payment for non-preferred 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 145mcg & 290mcg ☐ Movantik

Non-Preferred

☐ Ibsrela ☐ Linzess 72mcg ☐ Lubiprostone ☐ Motegrity ☐ Relistor ☐ Symproic ☐ Trulance

Strength	Dosage Instructions	Quantity	Days Supply

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:_____

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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 two 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 least 25% of bowel movements
  ☐ Sensation of incomplete evacuation for at least 25% of bowel movements
- Documentation the patient is not currently taking constipation causing therapies:
  Medication review completed: ☐ Yes ☐ No
  Current constipation causing therapies:
  ☐ Yes (please list) _____ ☐ No

☐ **Irritable Bowel Syndrome with Constipation:** (Amitiza, Ibsrela, 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 (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, Non-Cancer 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 Non-Preferred 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.

Prescriber signature (Must match prescriber listed above.)	Date of submission

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.*