

CONSTIPATION AGENTS PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis: <input type="checkbox"/> Opioid-induced constipation (OIC) <input type="checkbox"/> Chronic idiopathic constipation (CIC) <input type="checkbox"/> Irritable bowel syndrome with constipation (IBS-C) <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<p>For all requests:</p> <p>1. Is the patient currently being treated with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient currently stable on the requested agent? Please note, chart notes are required..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Does the patient have any FDA labeled contraindications to the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindications: _____</p> <p>3. Will the patient be using the requested agent in combination with another constipation agent (i.e., Amitiza/lubiprostone, Ibsrela, Linzess, Motegrity, Movantik, Relistor, Symproic, Trulance)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Is the patient's age within FDA labeling for the requested indication for the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide support for using the requested agent for the patient's age for the requested indication: _____</p> <p>5. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? Please note, chart notes are required <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Please continue to the next page.</p>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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8. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

For IBS-C and CIC requests:

9. Has the patient had symptoms of their condition for greater than or equal to 3 months? Yes No
10. Has the patient tried and had an inadequate response to at least 2 standard laxative therapy classes (e.g., bulk forming, stimulant, enema, osmotic, or stool softener)? Yes No
 If yes, please specify: _____
 If no, does the patient have an intolerance or hypersensitivity to at least 2 standard laxative therapy classes? Yes No
 If yes, please explain intolerance or hypersensitivity: _____

 If no, does the patient have an FDA labeled contraindication to ALL standard laxative therapy classes? ... Yes No
 If yes, please specify FDA labeled contraindication: _____

11. Is the requested agent Amitiza/lubiprostone? Yes No
 If yes, is the patient's sex female? Yes No
 If no, is the requested agent medically appropriate for the patient's sex and the intended diagnosis? Yes No

• **Please note, chart notes are required to support answers for the following questions:**

12. Has the patient tried and had an inadequate response to Trulance (plecanatide) and Linzess (linaclotide)? Yes No
13. Were Trulance (plecanatide) and Linzess (linaclotide) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
14. Does the patient have an intolerance or hypersensitivity to Trulance (plecanatide) and Linzess (linaclotide)? Yes No
15. Does the patient have an FDA labeled contraindication to Trulance (plecanatide) and Linzess (linaclotide) that is not expected to occur with the requested agent? Yes No
16. Are Trulance (plecanatide) and Linzess (linaclotide) expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
17. Are Trulance (plecanatide) and Linzess (linaclotide) not in the best interest of the patient based on medical necessity? Yes No
18. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as Trulance (plecanatide) and Linzess (linaclotide) and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

For OIC requests:

19. Does the patient have chronic non-cancer pain? Yes No
20. Does the patient have chronic pain related to prior cancer or its treatment? Yes No
21. Does the patient have active cancer pain? Yes No
22. Does the patient have advanced illness receiving palliative care or pain caused by active cancer receiving palliative care? Yes No
23. Does the patient have chronic use of an opioid agent in the past 30 days? Yes No
24. Is the patient currently receiving a diphenylheptane opioid (e.g., methadone)? Yes No

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For OIC requests continued:

25. Does the patient have advanced illness? Yes No
26. Is the patient receiving palliative care? Yes No
27. Has the patient tried and had an inadequate response to at least 2 standard laxative therapy classes (e.g., stimulant, enema, osmotic, or stool softener, but not including fiber or bulking agents)? Yes No
 If yes, please specify: _____
 If no, does the patient have an intolerance or hypersensitivity to at least 2 standard laxative therapy classes? Yes No
 If yes, please explain intolerance or hypersensitivity: _____
 If no, does the patient have an FDA labeled contraindication to ALL standard laxative therapy classes? ... Yes No
 If yes, please specify FDA labeled contraindication: _____

• **Please note, chart notes are required to support answers for the following questions:**

28. Has the patient tried and had an inadequate response to Symproic (naldemedine) and Movantik (naloxegol)?.. Yes No
29. Were Symproic (naldemedine) and Movantik (naloxegol) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
30. Does the patient have an intolerance or hypersensitivity to Symproic (naldemedine) and Movantik (naloxegol) that is not expected to occur with the requested agent? Yes No
31. Does the patient have an FDA labeled contraindication to Symproic (naldemedine) and Movantik (naloxegol)? Yes No
32. Are Symproic (naldemedine) and Movantik (naloxegol) expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
33. Are Symproic (naldemedine) and Movantik (naloxegol) not in the best interest of the patient based on medical necessity? Yes No
34. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as Symproic (naldemedine) and Movantik (naloxegol) and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?..... Yes No

For brand Amitiza requests:

35. Is there support for the use of the requested brand agent over the generic equivalent?..... Yes No
 If yes, please provide supporting information: _____

• **Please note, chart notes are required to support answers for the following questions:**

36. Has the patient tried and had an inadequate response to the generic equivalent (lubiprostone)?..... Yes No
37. Was the generic equivalent (lubiprostone) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?..... Yes No
38. Does the patient have an intolerance or hypersensitivity to the generic equivalent (lubiprostone) that is not expected to occur with the requested agent? Yes No
39. Does the patient have an FDA labeled contraindication to the generic equivalent (lubiprostone) that is not expected to occur with the requested agent? Yes No
40. Is the generic equivalent (lubiprostone) expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
41. Is the generic equivalent (lubiprostone) not in the best interest of the patient based on medical necessity? Yes No
42. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as the generic equivalent (lubiprostone) and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

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For renewal requests:

43. Has the patient had clinical benefit with the requested agent? Yes No

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121
TOLL FREE

Phone: **Fax: 877.243.6930**
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BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
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