US Family Health Plan
Prior Authorization Request Form for
plecanatide (Trulance), tenapanor hcl (Ibsrela)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Medical documentation required. Failure to provide could result in denial. Prior authorization expires after one year. For renewal of therapy an initial Tricare prior authorization approval is required.

1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Will the requested medication be used as dual therapy with Amitiza, Linzess, Motegrity, Symproic, Relistor, Movantik, Trulance (if the request is for Ibsrela) or Ibsrela (if the request is for Trulance)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **2**
2. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐ Yes Proceed to question **3**	☐ No Skip to question **4**
3. Has there been improvement in constipation symptoms?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
4. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have clinically diagnosed chronic idiopathic constipation or IBS-C (Irritable Bowel Syndrome with Constipation)?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have documented symptoms for greater than or equal to 3 months?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Does the patient have gastrointestinal obstruction?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **8**

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8. Is there documentation that the patient has failure with an increase in dietary fiber/dietary modification?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Has the patient tried and failed, has an intolerance or FDA-labeled contraindication to at least 2 standard laxative classes, defined as; ▪ **osmotic laxative (for example, lactulose, sorbitol magnesium [Mg] citrate, Mg hydroxide, glycerin rectal suppositories)** ▪ **bulk forming laxative (for example, psyllium, oxidized cellulose, calcium polycarbophil) with fluids** ▪ **stool softener (for example, docusate)** ▪ **stimulant laxative (for example, bisacodyl sennosides)**	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. What is the requested medication?	☐ Trulance **Sign and date below**	☐ Ibsrela **Proceed to question 11**
11. Has the patient tried and failed Linzess, Amitiza, and Trulance?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____

[10 August 2022]