

# US Family Health Plan

## Prior Authorization Request Form for Naloxegol (**Movantik**)

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 617-562-5296**

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**

Initial approval expires after 1 year, continuation approval expires after 1 year

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

Patient Name: _____ Address: _____ _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ _____ Phone #: _____ Secure Fax #: _____
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**Step 2** Please complete the clinical assessment:

1. Is this request for initial or continuation of therapy?	<input type="checkbox"/> Initial Proceed to question 2	<input type="checkbox"/> Continuation Proceed to question 10
2. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No Coverage not approved
3. Is the requested medication being prescribed for the treatment of opioid-induced constipation (OIC)?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Coverage not approved
4. Is the patient concurrently taking an opioid agonist (e.g., codeine, hydrocodone, hydromorphone, morphine)?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No Coverage not approved
5. Is the patient receiving other opioid antagonists (e.g., naloxone not including rescue agents, naltrexone, nalmefene)?	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> No Proceed to question 6
6. Has the patient tried and failed, or is unable to tolerate at least one stimulant laxative (e.g., sennosides or bisacodyl etc.)?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No Coverage not approved
7. Has the patient tried and failed, or is unable to tolerate at least one osmotic laxative (e.g., MiraLAX, lactulose, or magnesium citrate)?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No Coverage not approved
8. Does the patient have any of the following contraindications to the requested medication: known or suspected gastrointestinal obstruction or at an increased risk of recurrent obstruction?	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> No Proceed to question 9

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<b>9. Is the patient currently taking a strong CYP3A4 inhibitor (e.g., clarithromycin, ketoconazole)?</b>	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> No Sign and date below
<b>10. Is the patient continuing to take opioids?</b>	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No Coverage not approved
<b>11. Will the patient continue lifestyle modifications including regular use of a stimulant laxative (e.g. bisacodyl, senna), a high fiber diet, increased fluid intake, moderate exercise and opioid dose de-escalation to minimum effective dose?</b>	<input type="checkbox"/> Yes Proceed to question 12	<input type="checkbox"/> No Coverage not approved
<b>12. Is the patient responding in a meaningful manner (e.g. improvement of at least 1 additional spontaneous bowel movement per week over baseline)?</b>	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Coverage not approved

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

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Prescriber Signature

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Date

[ 10 October 2018 ]