

# US Family Health Plan

## Prior Authorization Request Form for prucalopride (**Motegrity**)

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**

**Prior authorization for initial therapy and renewal therapy will expire after 1 year.  
For renewal of therapy an initial US Family Health Plan prior authorization approval is required.**

**Step 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:

<b>1. Will the requested medication be used as dual therapy with Amitiza, Linzess, Trulance, Symproic, Relistor, or Movantik?</b>	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question <b>2</b>
<b>2. Has the patient received this medication under the TRICARE benefit in the last 6 months?</b> <i>Please choose "No" if the patient did not previously have a TRICARE/US Family Health Plan approved PA for Motegrity</i>	<input type="checkbox"/> Yes (subject to verification)  Proceed to question <b>12</b>	<input type="checkbox"/> No Proceed to question <b>3</b>
<b>3. Is the patient greater than or equal to 18 years of age?</b>	<input type="checkbox"/> Yes Proceed to question <b>4</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>4. Has the patient tried and failed all formulary agents including Amitiza, Linzess, and Trulance?</b>	<input type="checkbox"/> Yes Proceed to question <b>5</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>5. Does the patient have a diagnosis of chronic idiopathic constipation (CIC)?</b>	<input type="checkbox"/> Yes Proceed to question <b>6</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>6. Does the patient have documented symptoms for greater than or equal to 3 months?</b>	<input type="checkbox"/> Yes Proceed to question <b>7</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>7. Does the patient have documentation of failure with an increase in dietary fiber/dietary modification to relieve symptoms?</b>	<input type="checkbox"/> Yes Proceed to question <b>8</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>8. Does the patient have gastrointestinal obstruction?</b>	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question <b>9</b>

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<p><b>9. Has the patient tried and failed, has an intolerance or FDA-labeled contraindication to at least 2 standard laxative classes, defined as;</b></p> <ul style="list-style-type: none"> <li>▪ osmotic laxative (e.g., lactulose, sorbitol magnesium [Mg] citrate, Mg hydroxide, glycerin rectal suppositories)</li> <li>▪ bulk forming laxative (e.g., psyllium, oxidized cellulose, calcium polycarbophil) with fluids</li> <li>▪ stool softener (e.g., docusate)</li> <li>▪ stimulant laxative (e.g., bisacodyl sennosides)</li> </ul>	<input type="checkbox"/> Yes Proceed to question <b>10</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<p><b>10. Does the patient have a history of suicidal ideation?</b></p>	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question <b>11</b>
<p><b>11. Does the patient have low cardiovascular risk?</b></p>	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<p><b>12. Has the patient had improvement in constipation symptoms?</b></p>	<input type="checkbox"/> Yes Proceed to question <b>13</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<p><b>13. Is the patient being monitored for suicidal risk?</b></p>	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

\_\_\_\_\_

Prescriber Signature

\_\_\_\_\_

Date