US Family Health Plan
Prior Authorization Request Form
for **naldemedine (Symproic)**

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

Step 2

Please complete the clinical assessment:

1. Is this request for initial or continuation of therapy?	☐ Initial Proceed to question 2	☐ Continuation Proceed to question 12
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question 3	☐ No Coverage not approved
3. Is the requested medication being prescribed for the treatment of opioid-induced constipation (OIC)?	☐ Yes Proceed to question 4	☐ No Coverage not approved
4. Is the patient concurrently taking an opioid agonist (e.g., codeine, hydrocodone, hydromorphone, morphine)?	☐ Yes Proceed to question 5	☐ No Coverage not approved
5. Is the patient receiving other opioid antagonists (e.g., naloxone, naltrexone, nalmefene etc.)?	☐ Yes Coverage not approved	☐ 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.)?	☐ Yes Proceed to question 7	☐ 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)?	☐ Yes Proceed to question 8	☐ 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?	☐ Yes Coverage not approved	☐ No Proceed to question 9

Prior Authorization Request Form for

naldemedine (Symproic)

9. Is the patient currently taking a strong CYP3A4 inhibitor (e.g., clarithromycin, ketoconazole)?	☐ Yes Coverage not approved	☐ No Sign and date below
10. Is the patient continuing to take opioids?	☐ Yes Proceed to question 11	☐ No Coverage not approved
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?	☐ Yes Proceed to question 12	☐ No Coverage not approved
12. Is the patient responding in a meaningful manner (e.g. improvement of at least 1 additional spontaneous bowel movement per week over baseline)?	☐ Yes Sign and date below	☐ No Sign and date below

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

_____ _____

Prescriber Signature Date