US Family Health Plan
Prior Authorization Request Form for plecanatide (**Trulance**)

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 expires after one year. For renewal of therapy an initial TRICARE/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:**

Question	Yes	No
1. Will the requested medication be used as dual therapy with Amitiza, Linzess, Symproic, Relistor, or Movantik?	☐ 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 Trulance*	☐ 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**

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 (e.g., lactulose, sorbitol magnesium [Mg] citrate, Mg hydroxide, glycerin rectal suppositories)** ▪ **bulk forming laxative (e.g., psyllium, oxidized cellulose, calcium polycarbophil) with fluids** ▪ **stool softener (e.g., docusate)** ▪ **stimulant laxative (e.g., bisacodyl sennosides)**	☐ 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