

**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

Prior authorization expires after one year for the indication of chronic idiopathic constipation or IBS-C (Irritable Bowel Syndrome with Constipation). For renewal of therapy, an initial USFHP/Tricare prior authorization approval is required. Prior authorization does not expire for the indication of hyperphosphatemia in CKD patients receiving dialysis. Supporting clinical documentation is required.

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

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

Step 2 Please complete the clinical assessment:

1. What is the indication or diagnosis?	<input type="checkbox"/> Hyperphosphatemia in chronic kidney disease (CKD) - Proceed to question 2 <input type="checkbox"/> Chronic idiopathic constipation or IBS-C (Irritable Bowel Syndrome with Constipation) - Skip to question 10 <input type="checkbox"/> Other - STOP Coverage not approved	
2. What is the requested medication?	<input type="checkbox"/> Ibsrela Proceed to question 3	<input type="checkbox"/> Other STOP Coverage not approved
3. Is the patient greater than or equal to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Is the requested medication prescribed by or in consultation with a nephrologist?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Has the patient been receiving maintenance dialysis for at least 3 months?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Is the patient's serum phosphate level greater than 5.5 mg/dL and less than 10 mg/dL?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved

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<p>7. Has the patient tried and had an inadequate response to at least two phosphate binders (for example, sevelamer (Renagel, Renvela), lanthanum (Fosrenal), ferric citrate (Auryxiz), sucroferric oxyhydroxide (Velphoro), calcium carbonate, calcium acetate)?</p>	<p><input type="checkbox"/> Yes Sign and date below</p>	<p><input type="checkbox"/> No Proceed to question 8</p>
<p>8. Has the patient tried and been unable to tolerate at least two phosphate binders (for example, sevelamer (Renagel, Renvela), lanthanum (Fosrenal), ferric citrate (Auryxiz), sucroferric oxyhydroxide (Velphoro), calcium carbonate, calcium acetate)?</p>	<p><input type="checkbox"/> Yes Sign and date below</p>	<p><input type="checkbox"/> No Proceed to question 9</p>
<p>9. Does the patient have a contraindication to at least two phosphate binders (for example, sevelamer (Renagel, Renvela), lanthanum (Fosrenal), ferric citrate (Auryxiz), sucroferric oxyhydroxide (Velphoro), calcium carbonate, calcium acetate) intolerance to any dose of phosphate binder therapy. Contraindications to phosphate binders includes bowel obstruction, iron overload, or hypercalcemia?</p>	<p><input type="checkbox"/> Yes Sign and date below</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>10. 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)?</p>	<p><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 11</p>
<p>11. Has the patient received this medication under the USFHP/TRICARE benefit in the last 6 months? Choose "No" if the patient did not previously have a USFHP/TRICARE approved PA for the requested medication.</p>	<p><input type="checkbox"/> Yes Proceed to question 12</p>	<p><input type="checkbox"/> No Skip to question 13</p>
<p>12. Has there been improvement in constipation symptoms?</p>	<p><input type="checkbox"/> Yes Sign and date below</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>13. Is the patient greater than or equal to 18 years of age?</p>	<p><input type="checkbox"/> Yes Proceed to question 14</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>14. Does the patient have documented symptoms for greater than or equal to 3 months?</p>	<p><input type="checkbox"/> Yes Proceed to question 15</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>15. Does the patient have gastrointestinal obstruction?</p>	<p><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 16</p>
<p>16. Is there documentation that the patient has failure with an increase in dietary fiber/dietary modification?</p>	<p><input type="checkbox"/> Yes Proceed to question 17</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>

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<p>17. Has the patient tried and failed, has an intolerance or FDA-labeled contraindication to at least 2 standard laxative classes, defined as;</p> <ul style="list-style-type: none"> ▪ 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)? 	<p><input type="checkbox"/> Yes Proceed to question 18</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>18. What is the requested medication?</p>	<p><input type="checkbox"/> Trulance Sign and date below</p>	<p><input type="checkbox"/> Ibsrela Proceed to question 19</p>
<p>19. What is the patient's sex?</p>	<p><input type="checkbox"/> Male - Proceed to question 21 <input type="checkbox"/> Female - Proceed to question 20</p>	
<p>20. Has the patient tried and failed Linzess, Amitiza, and Trulance?</p>	<p><input type="checkbox"/> Yes Sign and date below</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>21. Has the patient tried and failed Linzess and Trulance?</p>	<p><input type="checkbox"/> Yes Sign and date below</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>

Step

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

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Prescriber Signature

Date

[2 April 2025]

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>