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 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 for initial therapy and renewal therapy will expire after 1 year.
For renewal of therapy, an initial USFHP 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:**

1. Will the requested medication be used as dual therapy with Amitiza, Linzess, Trulance, 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 Motegrity*	☐ Yes (subject to verification) Proceed to question **12**	☐ No Proceed to question **3**
3. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Has the patient tried and failed all formulary agents including Amitiza, Linzess, and Trulance?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Does the patient have a diagnosis of chronic idiopathic constipation (CIC)?	☐ 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 documentation of failure with an increase in dietary fiber/dietary modification to relieve symptoms?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved
8. Does the patient have gastrointestinal obstruction?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **9**

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 Proceed to question **10**	☐ No **STOP** Coverage not approved
10. Does the patient have a history of suicidal ?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **11**
11. What is the patient's cardiovascular risk?	☐ None/Low – **Sign and date below** ☐ Medium/High – **STOP** Coverage not approved	
12. Has the patient had improvement in constipation symptoms?	☐ Yes Proceed to question **13**	☐ No **STOP** Coverage not approved
13. Is the patient being monitored for suicidal risk?	☐ 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 _____

[14 August 2019]