

USFHP Prior Authorization Request Form for Naloxegol (Movantik)

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

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

Initial approval expires after 1 year, continuation approval expires after 1 year. For renewal of therapy an initial Tricare prior authorization approval 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:

2	1. 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 Movantik	<input type="checkbox"/> Yes (subject to verification) Proceed to question 10	<input type="checkbox"/> No Proceed to question 2
	2. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
	3. Is the requested medication being prescribed for the treatment of opioid-induced constipation (OIC)?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
	4. Is the patient concurrently taking an opioid agonist (e.g., codeine, hydrocodone, hydromorphone, morphine)?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
	5. Is the patient receiving other opioid antagonists (e.g., naloxone not including rescue agents, naltrexone, nalmefene)?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> 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.)?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP 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)?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No STOP 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?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 9

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9. Is the patient currently taking a strong CYP3A4 inhibitor (e.g., clarithromycin, ketoconazole)?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Sign and date below
10. Is the patient continuing to take opioids?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No STOP 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?	<input type="checkbox"/> Yes Proceed to question 12	<input type="checkbox"/> No STOP 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)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

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

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Prescriber Signature

Date

[25 July 2019]