IOWA Health and Human Services

Request for Prior Authorization

ORAL CONSTIPATION AGENTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for oral constipation agents subject to clinical criteria. Payment for non-preferred oral constipation agents will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred oral constipation agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met:

1) **Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and**
2) **Patient must have documentation of adequate trials and therapy failures with both of the following:**
    a. **Members 18 years of age and older:**
        i. **Stimulant laxative (senna) plus saline laxative (milk of magnesia); and**
        ii. **Stimulant laxative (senna) plus osmotic laxative (polyethylene glycol or lactulose); or**
    b. **Members 17 years of age or younger:**
        i. **Polyethylene glycol; and**
        ii. **One other preferred generic laxative, such as lactulose or senna; and**
3) **Patient does not have a known or suspected mechanical gastrointestinal obstruction.**

If the criteria for coverage are met, initial authorization will be given for 12 weeks to assess the response to treatment. Requests for continuation therapy may be provided if the prescriber documents adequate response to treatment and patient continues to meet the age for indication.

Preferred

☐ Linzess ☐ Lubiprostone ☐ Movantik

Non-Preferred

☐ Ibsrela ☐ Motegrity ☐ Prucalopride ☐ Symproic

Strength	Dosage Instructions	Quantity	Days Supply

Treatment failures:

Members 18 years of age and older:

Trial 1: Stimulant Laxative (senna) plus Osmotic Laxative (polyethylene glycol / lactulose)

Stimulant Laxative Trial: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

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Trial 2: Stimulant Laxative (senna) plus Saline Laxative (milk of magnesia)

Stimulant Laxative Trial: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Members 17 years of age and younger:

Polyethylene Glycol Trial: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Additional Preferred Generic Laxative Trial: Name/Dose:_____ Trial Dates: _____

Failure reason:_____

Does patient have a known or suspected mechanical gastrointestinal obstruction: ☐ Yes ☐ No

☐ **Chronic Idiopathic Constipation:** (Linzess, Lubiprostone or Motegrity)

- Patient has less than 3 spontaneous bowel movements (SBMs) per week:
  ☐ Yes ☐ No
- Patient has two or more of the following symptoms within the last 3 months:
  ☐ Straining during at least 25% of the bowel movements
  ☐ Lumpy or hard stools for at least 25% of bowel movements
  ☐ Sensation of incomplete evacuation for at least 25% of bowel movements
- Documentation the patient is not currently taking constipation causing therapies:
  Medication review completed: ☐ Yes ☐ No
  Current constipation causing therapies:
  ☐ Yes (please list)_____ ☐ No

☐ **Irritable Bowel Syndrome with Constipation:** (Ibsrela, Linzess or Lubiprostone)

- Patient is female (Lubiprostone requests only): ☐ Yes ☐ No
- Patient has recurrent abdominal pain on average at least 1 day per week in the last 3 months associated with two (2) or more of the following:
  ☐ Related to defecation
  ☐ Associated with a change in stool frequency
  ☐ Associated with a change in stool form

☐ **Opioid-Induced Constipation with Chronic, Non-Cancer Pain:** (Lubiprostone, Movantik or Symproic)

- Patient has been receiving stable opioid therapy for at least 30 days as seen in the patient's pharmacy claims: ☐ Yes ☐ No
- Patient has less than 3 spontaneous bowel movements (SBMs) per week, with at least 25% associated with one or more of the following:
  ☐ Hard to very hard stool consistency
  ☐ Moderate to very severe straining
  ☐ Sensation of incomplete evacuation

☐ **Functional Constipation:** (Linzess)

- Patient has less than 3 spontaneous bowel movements (SBMs) per week:
  ☐ Yes ☐ No
- Patient has one or more of the following criteria at least once per week for at least 2 months:
  ☐ History of stool withholding or excessive voluntary stool retention
  ☐ History of painful or hard bowel movements
  ☐ History of large diameter stools that may obstruct the toilet
  ☐ Presence of a large fecal mass in the rectum
  ☐ At least one episode of fecal incontinence per week

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☐ **Other Diagnosis:** _____

☐ **Renewal Requests:** Provide documentation of adequate response to treatment: _____

_____

Requests for Non-Preferred Oral Constipation Agent: Document trial of preferred agent

Drug Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*