PRIOR AUTHORIZATION REQUEST

Global Constipation

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is this request for initial therapy or for a continuation of therapy? [] Initial (If checked, go to 7) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication?	Yes	No

If you have any questions, call: 1-888-258-8250

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	[If no, skip to question 7.]		
3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	Does the patient have gastrointestinal obstruction? [If yes, no further questions.]	Yes	No
8	Does the provider confirm that he/she will not be using more than one agent together? [If no, no further questions.]	Yes	No
9	What is the diagnosis or indication? [] Irritable Bowel Syndrome with constipation (IBS-C) (If checked, go to 10) [] Functional Constipation (FC) (If checked, go to 22) [] Opioid Induced Constipation (OIC) (If checked, go to 29)		

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	[] Chronic Idiopathic Constipation (CIC) (If checked, go to 38) [] Other (If checked, no further questions)		
10	Is the patient greater than or equal to 18 years old? [If no, no further questions.]	Yes	No
11	Does the patient have BOTH of the following documented symptoms for at least 12 weeks within the last 12 months: A) Mean abdominal pain score greater than or equal to 3, B) Less than 3 complete spontaneous bowel movements per week? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Does the patient have documented failure with attempted lifestyle changes, including maintaining a diet rich in fiber and/or fiber supplementation along with adequate fluid intake? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Has the patient failed at least 4 weeks of therapy with one bulk forming laxative (for example, psyllium [Metamucil]) in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
14	Has the patient failed at least 4 weeks of therapy with polyethylene glycol (Miralax) in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	What medication is being requested? [] Lubiprostone (If checked, no further questions) [] Linzess (If checked, go to 16) [] Trulance (If checked, go to 17)		

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	[] Ibsrela (If checked, go to 19) [] Other (If checked, no further questions)		
16	Has the patient failed at least 4 weeks of therapy with Lubiprostone in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
17	Has the patient failed at least 4 weeks of therapy with Lubiprostone in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
18	Has the patient failed at least 4 weeks of therapy with Linzess in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
19	Has the patient failed at least 4 weeks of therapy with Lubiprostone in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	Has the patient failed at least 4 weeks of therapy with Linzess in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
21	Has the patient failed at least 4 weeks of therapy with Trulance in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
22	Is the patient between the age of 6 years and 17 years old? [If no, no further questions.]	Yes	No

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23	Does the patient have a documented history of less than 3 spontaneous bowel movements AND at least 1 of the following symptoms for at least 12 weeks within the last 12 months: A) History of painful or hard bowel movements, B) History of stool withholding or excessive voluntary stool retention, C) Greater than or equal to one episode of fecal incontinence per week, D) Presence of large fecal mass in the rectum? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
24	Does the patient have documented failure with attempted lifestyle changes, including maintaining a diet rich in fiber and/or fiber supplementation along with adequate fluid intake? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
25	Has the patient failed at least 4 weeks of therapy with one bulk forming laxative (for example, psyllium [Metamucil]) in the last 12 months unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
26	Has the patient failed at least 4 weeks of therapy with polyethylene glycol (Miralax) in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
27	Is the medication being prescribed by or in consultation with a gastroenterologist or a physician who specializes in the management of gastrointestinal disease? [If no, no further questions.]	Yes	No
28	What medication is being requested? [] Linzess (If checked, no further questions) [] Other (If checked, no further questions)		
29	Does the patient have a diagnosis of opioid induced constipation with an active opioid prescription not requiring frequent opioid dosage escalation? [If no, no further questions.]	Yes	No
30	Is the patient greater than or equal to 18 years old?	Yes	No

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	[If no, no further questions.]		
31	Does the patient have documented failure with attempted lifestyle changes, including maintaining a diet rich in fiber and/or fiber supplementation along with adequate fluid intake? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
32	Has the patient failed at least 4 weeks of therapy with one bulk forming laxative (for example, psyllium [Metamucil]) in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
33	Has the patient failed at least 4 weeks of therapy with polyethylene glycol (Miralax) in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
34	What medication is being requested? [] Lubiprostone (If checked, no further questions) [] Movantik (If checked, go to 35) [] Symproic (If checked go to 36) [] Other (If checked, no further questions)		
35	Has the patient failed at least 4 weeks of therapy with Lubiprostone in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
36	Has the patient failed at least 4 weeks of therapy with Lubiprostone in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

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37	Has the patient failed at least 4 weeks of therapy with Movantik in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
38	Is the patient greater than or equal to 18 years old? [If no, no further questions.]	Yes	No
39	Has the patient experienced at least 1 or more of the following symptoms for 12 weeks in the last 12 months: A) Sensation of incomplete evacuations for greater than or equal to 25 percent of defecations, B) Sensation of anorectal obstruction or blockage for greater than or equal to 25 percent of defecations, C) Straining during greater than or equal to 25 percent of defecations? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
40	Does the patient have documented failure with attempted lifestyle changes, including maintaining a diet rich in fiber and/or fiber supplementation along with adequate fluid intake? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
41	Has the patient failed at least 4 weeks of therapy with one bulk forming laxative (for example, psyllium [Metamucil]) in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
42	Has the patient failed at least 4 weeks of therapy with polyethylene glycol (Miralax) in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
43	Has the patient failed at least 4 weeks of therapy with a stimulant laxative (for example, castor oil, sennosides) in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
44	Is the medication being prescribed by or in consultation with a gastroenterologist or a physician who specializes in the management of gastrointestinal disease?	Yes	No

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	[If no, no further questions.]		
45	What medication is being requested? [] Lubiprostone (If checked, no further questions) [] Linzess (If checked, go to 46) [] Motegrity (If checked, go to 47) [] Trulance (If checked, go to 49) [] Other (If checked, no further questions)		
46	Has the patient failed at least 4 weeks of therapy with Lubiprostone in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
47	Has the patient failed at least 4 weeks of therapy with Lubiprostone in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
48	Has the patient failed at least 4 weeks of therapy with Linzess in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
49	Has the patient failed at least 4 weeks of therapy with Lubiprostone in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
50	Has the patient failed at least 4 weeks of therapy with Linzess in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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	[If no, no further questions.]		
51	Has the patient failed at least 4 weeks of therapy with Motegrity in the last 12 months, unless contraindicated? ACTION REQUIRED: Submit supporting documentation.	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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