AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Oral Constipation Agents

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
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 is required for oral constipation agents. Payment will be considered under the following conditions:

1) Patient is 18 years of age or older; and

2) Patient must have documentation of adequate trials and therapy failures with both of the following:

- Stimulant laxative (senna) plus saline laxative (milk of magnesia); and
- Stimulant laxative (senna) plus osmotic laxative (polyethylene glycol or lactulose).

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.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Non-Preferred

☐ Amitiza ☐ Linzess ☐ Movantik ☐ Relistor ☐ Trulance

Strength	Dosage instructions	Quantity	Days supply

Treatment failures:

Trial 1: Stimulant laxative (senna) plus osmotic laxative (polyethylene glycol / lactulose)

Stimulant laxative trial: Name/Dose:_____ Trial dates: _____

Failure reason: _____

Osmotic laxative trial: Name/Dose:_____ Trial dates: _____

Failure reason: _____

Trial 2: Stimulant laxative (senna) plus saline laxative (milk of magnesia)

Stimulant laxative trial: Name/Dose:_____ Trial dates: _____

Failure reason: _____

Saline laxative trial: Name/Dose:_____ Trial dates: _____

Failure reason: _____

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

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☐ **Chronic Idiopathic Constipation** — Amitiza or Linzess

- Patient has less than three spontaneous bowel movements (SBMs) per week: ☐ Yes ☐ No
- Patient has two or more of the following symptoms within the last three 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
- Medication review completed: ☐ Yes ☐ No

  Patient is currently taking constipation-causing therapies:

  ☐ Yes (please list) _____ ☐ No

☐ **Irritable Bowel Syndrome with Constipation** — Amitiza or Linzess

- Patient is female (Amitiza requests only): ☐ Yes ☐ No
- Patient has abdominal pain or discomfort at least three days per month in the last three months associated with two or more of the following:
  - ☐ Improvement with defecation
  - ☐ Onset associated with a change in stool frequency
  - ☐ Onset associated with a change in stool form

☐ **Opioid-Induced Constipation with Chronic, Non-Cancer Pain** — Amitiza, Movantik, or Relistor

- 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 three 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
- Patient has documentation of an adequate trial and therapy failure with Amitiza if prior authorization request is for a different oral constipation agent: ☐ Yes ☐ No

  Amitiza trial — Dose:_____ Trial dates: _____

  Failure reason: _____

☐ **Other diagnosis:** _____

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

_____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste, and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

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 that the member continues to be eligible for Medicaid by inspection of the member's Medicaid eligibility card and/or contacting the county Department of Human Services.

Check www.amerihealthcaritasia.com/provider to confirm your version of this form.