PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

Relistor Movantik Symproic - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Relistor Movantik Symproic - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Movantik (naloxegol) Relistor (methylnaltrexone) Symproic (naldemedine)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is this request for continuation of therapy? Y N

[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]

[If no, then skip to question 3.]

2. Is the patient showing adequate response from treatment? Y N _____

	[Note: Clinical documentation must be submitted.]		
	[No further questions.]		
3.	Is the patient 18 years of age or older?	Y N	
	[If no, then no further questions.]		
4.	Is the requested drug being used for the treatment of constipation due to non-opioid causes?	Y N	
	[If yes, then no further questions.]		
5.	Is the requested drug being prescribed for use in the presence of bowel obstruction?	Y N	
	[If yes, then no further questions.]		
6.	Does the patient have the documented diagnosis of opioid-induced constipation due to continuous use of a long-acting opioid agent (e.g., Oxycontin, fentanyl patches, etc.)?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
7.	Does the patient have the documented diagnosis of chronic non-cancer pain, including pain associated with prior cancer or its treatment, which precludes the discontinuation of the long-acting opioid agent?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no skip to question 11.]		
8.	Has the patient had a trial and inadequate response to both of the following: A) 3 or more conventional formulary laxatives for at least one month each, B) lubiprostone?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
9.	Is this request for Relistor?	Y N	
	[If no, then no further questions.]		
10.	Has the patient had a trial and inadequate response to both of the following: A) Movantik, B) Symproic?	Y N	
	[Note: Documentation must be submitted.]		
	[No further questions.]		
11.	Is this request for Relistor subcutaneous injection?	Y N	
	[If no, then no further questions.]		
12.	Does the patient have documented pain associated with an advanced illness, or active cancer?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
13.	Is the patient receiving palliative care?	Y N	
	[If no, then no further questions.]		

14. Has the patient had a trial and failure of 3 or more conventional formulary laxatives for at least one month each?	Y N	
[Note: Documentation must be submitted.]		
[If no, then no further questions.]		
15. Does the patient have cancer-related pain?	Y N	
[If yes, then no further questions.]		
16. Has the patient had a trial and failure of all of the following: A) lubiprostone, B) Movantik, C) Symproic?	Y N	
[Note: Documentation must be submitted.]		

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date