JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Will the requested medication be used as dual therapy with Amitiza, Linzess, Trulance, Symproic, Relistor, or Movantik?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **2**
2. 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 Motegrity*	☐ Yes (subject to verification) Proceed to question **12**	☐ No Proceed to question **3**
3. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Has the patient tried and failed all formulary agents including Amitiza, Linzess, and Trulance?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Does the patient have a diagnosis of chronic idiopathic constipation (CIC)?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
6. Does the patient have documented symptoms for greater than or equal to 3 months?	☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved
7. Does the patient have documentation of failure with an increase in dietary fiber/dietary modification to relieve symptoms?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved
8. Does the patient have gastrointestinal obstruction?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **9**

9. Has the patient tried and failed, has an intolerance or FDA-labeled contraindication to at least 2 standard laxative classes, defined as; ▪ **osmotic laxative (e.g., lactulose, sorbitol magnesium [Mg] citrate, Mg hydroxide, glycerin rectal suppositories)** ▪ **bulk forming laxative (e.g., psyllium, oxidized cellulose, calcium polycarbophil) with fluids** ▪ **stool softener (e.g., docusate)** ▪ **stimulant laxative (e.g., bisacodyl sennosides)**	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
10. Does the patient have a history of suicidal ideation?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **11**
11. Does the patient have low cardiovascular risk?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
12. Has the patient had improvement in constipation symptoms?	☐ Yes Proceed to question **13**	☐ No **STOP** Coverage not approved
13. Is the patient being monitored for suicidal risk?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3

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

_____ _____

Prescriber Signature Date

[14 August 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: