Prior Authorization Request Form for
naldemedine (Symproic)

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

USFHP Pharmacy Prior Authorization Form

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

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. 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 Symproic*	☐ Yes (subject to verification) Proceed to question **10**	☐ No Proceed to question **2**
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the requested medication being prescribed for the treatment of opioid-induced constipation (OIC)?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the patient concurrently taking an opioid agonist (e.g., codeine, hydrocodone, hydromorphone, morphine)?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the patient receiving other opioid antagonists (e.g., naloxone, naltrexone, nalmefene etc.)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **6**
6. Has the patient tried and failed, or is unable to tolerate at least one stimulant laxative (e.g., sennosides or bisacodyl etc.)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient tried and failed, or is unable to tolerate at least one osmotic laxative (e.g., MiraLAX, lactulose, or magnesium citrate)?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have any of the following contraindications to the requested medication: known or suspected gastrointestinal obstruction or at an increased risk of recurrent obstruction?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**

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9. Is the patient currently taking a strong CYP3A4 inhibitor (e.g., clarithromycin, ketoconazole)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
10. Is the patient continuing to take opioids?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Will the patient continue lifestyle modifications including regular use of a stimulant laxative (e.g. bisacodyl, senna), a high fiber diet, increased fluid intake, moderate exercise and opioid dose de-escalation to minimum effective dose?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Is the patient responding in a meaningful manner (e.g. improvement of at least 1 additional spontaneous bowel movement per week over baseline)?	☐ 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

[25 July 2019]

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