Prior Authorization Request Form for
plecanatide (Trulance)

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. Will the requested medication be used as dual therapy with Amitiza, Linzess, 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 Trulance*	☐ Yes Proceed to question **3**	☐ No Skip to question **4**
3. Has there been improvement in constipation symptoms?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
4. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have clinically diagnosed chronic idiopathic constipation or IBS-C (Irritable Bowel Syndrome with Constipation)?	☐ 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 gastrointestinal obstruction?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **8**

8. Is there documentation that the patient has failure with an increase in dietary fiber/dietary modification?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
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 **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 _____

[12 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: