

□ No □ Yes

Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Motegrity (prucalopride) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Motegrity (prucalopride)**. Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: <u>1-866-331-2104</u>]. If you have any questions or concerns, please call <u>1-866-331-2103</u>. **Requests will not be considered unless this form is complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information			
Patient Name:	Kaiser Medical ID#:	Date of Birth:	
2 – Provider Information			
Provider Name:	Specialty:	NPI:	
Provider Address:			
Provider Phone #:	Provider Fax #:		
3 – Pharmacy Information			
Pharmacy Name:	Pharmacy NPI:		
Pharmacy Phone #	Pharmacy Fax #:		
4 – Drug Therapy Requested			
3ig			
Drug 2: Name/Strength/Formulation:			
Sig:			
	5- Diagnosis/Clinical Criteria		
1. Is this request for initial or continu	ing therapy?		
☐ Initial therapy	☐ Continuing therapy, State date:		
2. Indicate the patient's diagnosis for	the requested medication:		
Clinical Criteria: 1. Prescribed by a Gastroenterologist	t or in consultation with a Gastroenterologis	t,	

2.	AND member has a diagnosis of chronic idiopathic constipation, □ No □ Yes	
3.	AND member has had an inadequate response, contraindication, or intolerance to an adequate trial of at least 4 weeks or intolerance to scheduled doses of the following medications:	
	- Fiber supplement: psyllium fiber or methylcellulose	
	- Osmotic laxative: polyethylene glycol or lactulose	
	- Stimulant laxative: senna or bisacodyl	
	- Amitiza (lubiprostone) - also criteria based	
	- Trulance (plecanatide) - also criteria based	
	□ No □ Yes	
Fo	r continuation of therapy, please respond to <u>additional questions</u> below:	
1.	Member has a positive clinical response to Motegrity	
	□ No □ Yes	
7 – Provider Sign-Off		
1. 2.	ditional Information – Please submit chart notes/medical records for the patient that are applicable to this request. If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:	
I certify that the information provided is accurate. Supporting documentation is available for State audits.		
Pr	ovider Signature: Date:	
pri	ase Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is vate and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of vaction in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility	

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