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: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **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

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?

   □ Initial therapy □ Continuing therapy, State date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Prescribed by a Gastroenterologist or in consultation with a Gastroenterologist,

   □ No □ Yes

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

For 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

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **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.

Provider Signature:	**Date:**