Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Movantik (naloxegol) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Movantik (naloxegol).**
Please complete all sections, incomplete forms will delay processing. 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 all sections are 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 – Prescriber Information

Prescriber Name: ______________________________ Specialty: _________________________ NPI: ___________________

Prescriber Address: ____

Prescriber Phone #: _________________________Prescriber 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 start date: __________________________________
2. Indicate the patient's diagnosis for the requested medication: ____

Clinical Criteria:

1. Prescriber is a Gastroenterologist, Oncologist, or Pain Specialist,

□ No □ Yes

2. **AND** member has a diagnosis of opioid induced constipation in an adult with an active opioid prescription
   □ No □ Yes

3. **AND** opioid medication is being prescribed by an oncologist or a hospice/palliative care clinician for a member currently enrolled in hospice or palliative care program, or after consultation with a pain management specialist
   □ No □ Yes

4. **AND** member has failed a trial of at least 2 weeks or has an intolerance or contraindication to scheduled dosing of the following medications, used in combination with other agent(s) with different mechanism of action (i.e., osmotic with a stimulant) and route of administration:
   - Polyethylene glycol
   - Lactulose or sorbitol
   - Senna
   - Bisacodyl

   □ No □ Yes

5. **AND** member has inadequate response, contraindication or intolerance to generic Amitiza
   □ No □ Yes

For continuation of therapy, please respond to additional question below:

1. Member has a positive clinical response to Movantik
   □ No □ Yes

6 – Prescriber 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:**

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I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**

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