Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Symproic (naldemedine) 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 **Symproic (naldemedine).** 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 both of the following:
   - Generic Amitiza (lubiprostone) – 1st line
   - Movantik – 2nd line
   □ No □ Yes

For continuation of therapy, please respond to <u>additional question</u> below:

1. Member has a positive clinical response to Symproic
   □ 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:**

_____

_____

_____

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

Prescriber Signature:	**Date:**