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:**

____
____
____

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

Prescriber Signature:	**Date:**
Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private 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 any action 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	