Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Constipation Agents – Medical Necessity Request

A. General Information:

1. **For Linzess, Movantik, Relistor, Trulance, Symproic, Motegrity, Zelnorm, and Ibsrela requests only**: Can the prescription be changed to Amitiza?
   □ Yes: Please notify the pharmacy of the change and proceed to section B.
   □ No: Please provide the clinical reason why Amitiza cannot be tried, then proceed to section B.
   _____

B. **Contraindication Information:** Please indicate if the member has any of the listed contraindications for the requested drug.

Amitiza, Linzess, Trulance, Ibsrela	Movantik	Relistor or Symproic	Motegrity	Zelnorm	
□ Known or suspected mechanical gastrointestinal (GI) obstruction □ NONE	□ Known or suspected mechanical gastrointestinal (GI) obstruction and at risk of recurrent obstruction □ Concomitant use with strong CYP3A4 inhibitors (e.g., clarithromycin, ketoconazole, itraconazole) □ NONE	□ Known or suspected mechanical gastrointestinal (GI) obstruction and at an increased risk of recurrent obstruction □ NONE	□ Intestinal perforation or obstruction due to structural or functional disorder of gut wall □ Obstructive ileus □ Severe inflammatory conditions of intestinal tract (e.g., Crohn disease, ulcerative colitis, toxic megacolon/megarectum) □ NONE	□ History of abdominal adhesions, bowel obstruction, ischemic colitis or other forms of intestinal ischemia, suspected sphincter of Oddi dysfunction, or symptomatic gallbladder disease □ History of myocardial infarction, stroke, transient ischemic attack, or angina □ Moderate and severe hepatic impairment (Child-Pugh B or C) □ Severe renal impairment (eGFR less than 15 mL/min/1.73 m2) or end stage renal disease □ NONE	

C. **Diagnosis Information**:

1. Does the member have constipation?
   □ **No:** What is the member's diagnosis? _____
   □ **Yes:** Please indicate the cause of the constipation below and answer any associated questions.

   □ **Opioid Use**
   a. What opioid therapy is the member currently receiving and when was it last received? [NOTE: Examples of opioids include: oxycodone, hydrocodone, morphine, OxyContin, MS Contin, Kadian, Duragesic/Fentanyl]
      _____
      _____
   b. Does member have chronic pain? **Yes or No**
   c. Is the pain associated with cancer? **Yes or No**
      - If no, please proceed to letter d.
      - If yes, has the member tried any of the following laxatives: an osmotic agent (e.g. Polyethylene glycol, lactulose, Milk of Magnesia), stimulant laxative (e.g. senna, bisacodyl), or lubricant (e.g. mineral oil)?
        □ **Yes:** Please provide the names of the laxatives tried and reason discontinued.
        _____
        _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

□ **No –** Can the member try laxative therapy before the requested medication?

□**Yes:** please provide the name of the new medication and call the prescription for the new medication into the pharmacy. _____

□**No:** Please provide the clinical reason why laxative therapy cannot be tried.

_____

d. Is the pain associated with prior cancer or its treatment and does it not require frequent (e.g. weekly) opioid dosage escalation? **Yes or No**

e. Does the member have an advanced illness? **Yes or No ****If yes, please answer the following question.

i. Is the member receiving palliative care? **Yes or No**

f. Has the member tried any of the following laxatives: an osmotic agent (e.g. Polyethylene glycol, lactulose, Milk of Magnesia), stimulant laxative (e.g. senna, bisacodyl), lubricant (e.g. mineral oil), or stool softener (docusate)?

□ **Yes:** Please provide the names of the laxatives tried and reason discontinued.

_____

_____

□ **No –** Can the member try laxative therapy before the requested medication?

□**Yes:** please provide the name of the new medication and call the prescription for the new medication into the pharmacy. _____

□**No:** Please provide the clinical reason why laxative therapy cannot be tried.

g. Were laxatives tried:

□ on a scheduled basis

□ on an as needed (prn) basis

□ **Irritable Bowel Syndrome**

a. Has the member tried and had an inadequate response to fiber supplementation (e.g. psyllium)?

□ **Yes**

□ **No –** Can the member try fiber supplementation before the requested medication?

□**Yes:** please provide the name of the new medication and call the prescription for the new medication into the pharmacy. _____

□**No:** Please provide the clinical reason why fiber supplementation cannot be tried.

_____

□ **Unknown Cause (Idiopathic)**

a. Does the member have acute or chronic constipation? **Acute or Chronic**

b. Has the member tried any of the following laxatives: an osmotic agent (e.g. Polyethylene glycol, lactulose, Milk of Magnesia), stimulant laxative (e.g. senna, bisacodyl), fiber supplementation, lubricant (e.g. mineral oil), or stool softener (docusate)?

□**Yes:** Please provide the names of the laxatives tried and reason discontinued.

_____

_____

□**No –** Can the member try laxative therapy before the requested medication?

□**Yes:** please provide the name of the new medication and call the prescription for the new medication into the pharmacy. _____

□**No:** Please provide the clinical reason why laxative therapy cannot be tried.

_____

□ **Other**: _____

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**