SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization may be delayed.**

Gastrointestinal (GI) Motility Drugs

Drug Requested: (select one drug below)

Non-Preferred		
❑ **Ibsrela®** (tenapanor)	❑ **prucalopride** (generic Motegrity®)	❑ **Relistor®** (methylnaltrexone bromide)
❑ **Trulance®** (plecanatide)	❑ **Zelnorm™** (tegaserod)	

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

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❑ Approval of prucaloride (generic Motegrity®) for diagnosis of Chronic Idiopathic Constipation (CIC)

❑ Member has had trial and failure, contraindication, or intolerance to **ONE** of the following generic prerequisite therapies:

❑ lactulose	❑ polyethylene glycol (generic MiraLAX®)

AND

❑ Member has had trial and failure, contraindication, or intolerance to lubiprostone (Amitiza®)

AND

❑ Member has had trial and failure, contraindication, or intolerance to Linzess®

❑ Approval of Zelnorm™

❑ Diagnosis of **Irritable Bowel Syndrome with Constipation (IBS-C)**

AND

❑ Member is < 65 years of age with no history of ischemic cardiovascular disease and has no more than one CVD risk factor. CVD risk factors are defined as active smoking, current hypertension/history of antihypertensive treatment, current hyperlipidemia/history of lipid lowering medication, history of diabetes mellitus, age >55 years, or obesity (BMI >30 kg/m^2)

AND

❑ Provider attests that member does **NOT** have any of the following contraindications to therapy:

- History of myocardial infarction (MI), stroke, transient ischemic attack (TIA), or angina
- History of ischemic colitis or other forms of intestinal ischemia
- Severe renal impairment (eGFR < 15 mL/min/1.73 m^2) or end-stage renal disease
- Moderate and severe hepatic impairment (Child-Pugh B or C)
- History of bowel obstruction, symptomatic gallbladder disease, suspected sphincter of Oddi dysfunction, or abdominal adhesions

AND

❑ Member has had trial and failure, contraindication, or intolerance to **ONE** of the following generic prerequisite therapies:

❑ lactulose	❑ polyethylene glycol (generic MiraLAX®)

AND

❑ Member has had trial and failure, contraindication, or intolerance to lubiprostone (Amitiza®)

AND

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- ❑ Member has had trial and failure, contraindication, or intolerance to Linzess®

❑ Approval of Trulance® for diagnosis of Irritable Bowel Syndrome with Constipation (IBS-C) or Chronic Idiopathic Constipation (CIC)

- ❑ Member has had trial and failure, contraindication, or intolerance to **ONE** of the following generic prerequisite therapies:

❑ lactulose	❑ polyethylene glycol (generic MiraLAX®)

AND

- ❑ Member has had trial and failure, contraindication, or intolerance to lubiprostone (Amitiza®)

AND

- ❑ Member has had trial and failure, contraindication, or intolerance to Linzess®

❑ Approval of Ibsrela® for diagnosis of Irritable Bowel Syndrome with Constipation (IBS-C)

- ❑ Member has had trial and failure, contraindication, or intolerance to **ONE** of the following generic prerequisite therapies:

❑ lactulose	❑ polyethylene glycol (generic MiraLAX®)

AND

- ❑ Member has had trial and failure, contraindication, or intolerance to lubiprostone (Amitiza®)

AND

- ❑ Member has had trial and failure, contraindication, or intolerance to Linzess®

AND

- ❑ Member has had trial and failure, contraindication, or intolerance to Trulance® **(requires prior authorization)**

❑ Approval of Relistor®

Recommended Dosing:

Weight of Adult Patient	Subcutaneous Dose	Injection Volume
Less than 38kg	0.15 mg/kg	See below
38kg to less than 62 kg	8mg	0.4 mL
62kg to 114kg	12mg	0.6 mL
More than 114kg	0.15 mg/kg	See below

Calculate injection volume by multiplying member weight in kilograms by 0.0075, then round up the volume to the nearest 0.1 mL

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- ❑ Select **ONE** of the following:
  - ❑ Member has a diagnosis of opioid-induced constipation (OIC) with advanced illness or pain caused by active cancer who require opioid dosage escalation for palliative care
  - ❑ Member has a diagnosis of opioid-induced constipation (OIC) with chronic non-cancer pain, including members with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation

AND

- ❑ Member has been on an opioid within the last 60 days of prior authorization request but not less than 4 weeks. Provider please note: Members receiving opioids for less than 4 weeks may be less responsive to Relistor®

AND

- ❑ Member has had trial and failure, contraindication, or intolerance to **ONE** of the following generic prerequisite therapies:

❑ lactulose	❑ polyethylene glycol (generic MiraLAX®)

AND

- ❑ Member has had trial and failure, contraindication, or intolerance to lubiprostone (Amitiza®)

AND

- ❑ Member has had trial and failure, contraindication, or intolerance to both Movantik® **AND** Symproic®

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: 10/15/2015
REVISED/UPDATED/REFORMATTED: ~~8/2/2019; 9/14/2019; 6/1/2020; 8/31/2020; 12/23/2020; 8/11/2021; 6/24/2022; 3/2/2023; 7/11/2023;~~ **2/19/2025**