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, or Symproic 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	Movantik	Relistor or Symproic
□ Known or suspected mechanical gastrointestinal (GI) obstruction □ NONE	□ Known or suspected mechanical gastrointestinal (GI) 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

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**
   d. 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**

   e. 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.
         ____

   f. Were laxatives tried:
      □ on a scheduled basis
      □ on an as needed (prn) basis

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: __________________

□ **Irritable Bowel Syndrome**

□ **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**