

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:**

- 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.

<b>Amitiza, Linzess, Trulance, Ibsrela</b>	<b>Movantik</b>	<b>Relistor or Symproic</b>	<b>Motegrity</b>	<b>Zelnorm</b>
<input type="checkbox"/> Known or suspected mechanical gastrointestinal (GI) obstruction  <input type="checkbox"/> NONE	<input type="checkbox"/> Known or suspected mechanical gastrointestinal (GI) obstruction  <input type="checkbox"/> Concomitant use with strong CYP3A4 inhibitors (e.g., clarithromycin, ketoconazole, itraconazole)  <input type="checkbox"/> NONE	<input type="checkbox"/> Known or suspected mechanical gastrointestinal (GI) obstruction and at an increased risk of recurrent obstruction  <input type="checkbox"/> NONE	<input type="checkbox"/> Intestinal perforation or obstruction due to structural or functional disorder of gut wall  <input type="checkbox"/> Obstructive ileus  <input type="checkbox"/> Severe inflammatory conditions of intestinal tract (e.g., Crohn disease, ulcerative colitis, toxic megacolon/megarectum)  <input type="checkbox"/> NONE	<input type="checkbox"/> History of abdominal adhesions, bowel obstruction, ischemic colitis or other forms of intestinal ischemia, suspected sphincter of Oddi dysfunction, or symptomatic gallbladder disease  <input type="checkbox"/> History of myocardial infarction, stroke, transient ischemic attack, or angina  <input type="checkbox"/> Moderate and severe hepatic impairment (Child-Pugh B or C)  <input type="checkbox"/> Severe renal impairment (eGFR less than 15 mL/min/1.73 m <sup>2</sup> ) or end stage renal disease  <input type="checkbox"/> NONE

**C. Diagnosis Information:**

- 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), lubricant (e.g. mineral oil), or stool softener (docusate)?

**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), 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.

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