Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Print Clear

Constipation Agents
Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Constipation agent requested

☐ Amitiza (lubiprostone)
☐ lactulose packet
☐ Linzess (linaclotide)
☐ Motegrity (prucalopride)
☐ Movantik (naloxegol)
☐ Relistor (methylnaltrexone)
☐ Symproic (naldemedine)
☐ Trulance (plecanatide)

Dose, frequency, and duration of medication requested _____

Indication (Check all that apply.)

☐ Chronic idiopathic constipation
☐ Irritable bowel syndrome with constipation
☐ Opioid-induced constipation
☐ Other _____

Section I. Please complete for Amitiza, Linzess, Motegrity, Movantik, Symproic, and Trulance requests.

1. Has the member had a trial with a bulk forming laxative? ☐ Yes. Drug name _____ ☐ No
2. Has the member had a trial with a saline laxative? ☐ Yes. Drug name _____ ☐ No
3. Has the member had a trial with an osmotic laxative? ☐ Yes. Drug name _____ ☐ No
4. Has the member had a trial with a stimulant laxative? ☐ Yes. Drug name _____ ☐ No
5. For Motegrity, Movantik, Symproic, and Trulance has the member had a trial with Amitiza? ☐ Yes ☐ No
6. For Amitiza, Movantik, and Symproic does the member have chronic, non-cancer pain? ☐ Yes ☐ No

Section II. Please complete for lactulose packet requests.

Please attach medical records documenting an adverse reaction or contraindication to lactulose solution.

Section III. Please complete for Relistor requests.

1. Does the member have an advanced illness for which the member is receiving palliative care?
   ☐ Yes. Diagnosis _____ ☐ No
2. Does the member have chronic, non-cancer pain? ☐ Yes ☐ No

3. Has the member had a trial with a bulk forming laxative? ☐ Yes. Drug name _____ ☐ No
4. Has the member had a trial with a saline laxative? ☐ Yes. Drug name _____ ☐ No
5. Has the member had a trial with an osmotic laxative? ☐ Yes. Drug name _____ ☐ No
6. Has the member had a trial with a stimulant laxative? ☐ Yes. Drug name _____ ☐ No
7. Has the member had a trial with Movantik?
   ☐ Yes. Please list the dates/duration of use and outcomes below.*
   Dates/duration of use _____ Outcome _____
   ☐ No. Please document if there is a contraindication to Movantik therapy.
   _____
8. Has the member had a trial with Amitiza?
   ☐ Yes. Please list the dates/duration of use and outcomes below.*
   Dates/duration of use _____ Outcome _____
   ☐ No. Please document if there is a contraindication to Amitiza therapy.
   _____
9. Has the member had a trial with Linzess?
   ☐ Yes. Please list the dates/duration of use and outcomes below.*
   Dates/duration of use _____ Outcome _____
   ☐ No. Please document if there is a contraindication to Linzess therapy.
   _____

** Attach a letter with additional information regarding medication trials as applicable.*

Section IV. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

_____

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

* *Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____