



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

## 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](http://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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Amitiza (lubiprostone)   | <input type="checkbox"/> Movantik (naloxegol)   | <input type="checkbox"/> Trulance (plecanatide) |
| <input type="checkbox"/> lactulose packet         | <input type="checkbox"/> Relistor               |   |
| <input type="checkbox"/> Linzess (linaclotide)    | (methylnaltrexone)                              |   |
| <input type="checkbox"/> Motegrity (prucalopride) | <input type="checkbox"/> Symproic (naldemedine) |   |

**Dose, frequency, and duration of medication requested** \_\_\_\_\_

#### Indication (Check all that apply.)

- |   |  |
|---|--|
| <input type="checkbox"/> Chronic idiopathic constipation            | <input type="checkbox"/> Opioid-induced constipation |
| <input type="checkbox"/> Irritable bowel syndrome with constipation | <input type="checkbox"/> Other _____                 |

### Section I. Please complete for all requests, excluding lactulose packet. For Motegrity, Movantik, Relistor, Symproic, and Trulance requests, please also complete Section II below as appropriate.

- Has the member had a trial with a bulk-forming laxative?  Yes. Drug name \_\_\_\_\_  No
- Has the member had a trial with a saline laxative?  Yes. Drug name \_\_\_\_\_  No
- Has the member had a trial with an osmotic laxative?  Yes. Drug name \_\_\_\_\_  No
- Has the member had a trial with a stimulant laxative?  Yes. Drug name \_\_\_\_\_  No
- For Amitiza, Movantik, Relistor, and Symproic does the member have chronic, non-cancer pain?  
 Yes  No
- For Relistor, does the member have an advanced illness for which the member is receiving palliative care?  
 Yes. Diagnosis \_\_\_\_\_  No

### Section II. Please also complete for Motegrity, Movantik, Relistor, Symproic, and Trulance requests. Please complete Section I above as appropriate.

- Has the member had a trial with Amitiza?  
 Yes. Please list the dates/duration of use and outcomes below.\*  
 Dates/duration of use \_\_\_\_\_ Outcome \_\_\_\_\_ over \_\_\_\_\_

No. Please document if there is a contraindication to Amitiza therapy.

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2. 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.

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3. For Relistor, 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.

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### Section III. Please complete for lactulose packet requests.

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

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

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### 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.

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### 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

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### 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 \_\_\_\_\_