



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations. Visit go.covermymeds.com/OptumRx to begin using this free service. Please note: All information below is required to process this request. Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Movantik® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

| Member Information <small>(required)</small> | | | Provider Information <small>(required)</small> | | |
|---|--------|------|--|--------|--------------|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | | Specialty: |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |
| Medication Information <small>(required)</small> | | | | | |
| Medication Name: | | | Strength: | | Dosage Form: |
| <input type="checkbox"/> Check if requesting brand | | | Directions for Use: | | |
| <input type="checkbox"/> Check if request is for continuation of therapy | | | | | |
| Clinical Information <small>(required)</small> | | | | | |
| Select the diagnosis below: <input type="checkbox"/> Opioid-induced constipation (OIC) in patients with chronic non-cancer pain <input type="checkbox"/> Opioid-induced constipation (OIC) in patients with chronic pain related to prior cancer diagnosis or cancer treatment who do not require frequent (e.g., weekly) opioid dosage escalation <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____ | | | | | |
| Select the medications the patient has had a trial and failure, contraindication, or intolerance to: <input type="checkbox"/> Lactulose <input type="checkbox"/> Polyethylene glycol (Please document date of trial): Date: _____ <input type="checkbox"/> Symproic <input type="checkbox"/> Other OTC laxative (Please document name and date of trial): Medication name: _____ Date: _____ | | | | | |
| Reauthorization: For reauthorization requests, also answer the following: Is there documentation of positive clinical response to Movantik therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Quantity limit requests: What is the quantity requested per DAY? _____ What is the reason for exceeding the plan limitations? <input type="checkbox"/> Titration or loading dose purposes <input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> Other: _____ | | | | | |

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received. For urgent or expedited requests please call 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-800-527-0531.