



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) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Please answer the following: Does the patient have chronic pain that is NOT associated with cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have chronic pain related to PRIOR cancer or its treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No Select the medications the patient has a failure, contraindication, or intolerance to: <input type="checkbox"/> Amitiza <input type="checkbox"/> Constulose <input type="checkbox"/> Enulose <input type="checkbox"/> Generlac <input type="checkbox"/> Kristalose <input type="checkbox"/> Lactulose <input type="checkbox"/> Relistor solution <input type="checkbox"/> Relistor tablet <input type="checkbox"/> Symproic <input type="checkbox"/> Other osmotic laxative [e.g., Miralax/PEG3350 (polyethylene glycol)]					
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"/> There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. Please specify: _____ <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.
 If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-844-403-1028.

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