



Please note: All information below is required to process this request.  
 Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern



## Movantik® Prior Authorization Request Form

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

Member Information (required)			Provider Information (required)		
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 (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information (required)					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Opioid induced constipation					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Clinical information:</b>					
Is the patient being treated for chronic, non-cancer pain? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient tried and failed one (1) of the following: Lactulose or polyethylene glycol? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Quantity limit requests:</b>					
What is the quantity requested per DAY? _____					
Previous therapies failed and/or therapies currently used in combination with the requested medication ( <i>List ALL medications tried or authorization process will be delayed</i> ): _____					
Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If <b>Yes</b> , please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature).					
** Please note: Chart documentation of the above is required to be submitted along with this fax					
<b>Medication being provided by:</b> (Please check applicable box below)					
<input type="checkbox"/> PropriumRx <input type="checkbox"/> Specialty Pharmacy (specify name): _____					
<b>**Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.**</b>					
<b>*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*</b>					
<b>Prescriber Signature:</b> _____ <b>Date:</b> _____					

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.

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