UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

PAMORAs

(Movantik, Symproic)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (*All* of the following criteria must be met):

1. Is the patient 18 years of age or older? ❑ **Yes** ❑ **No**
2. Does the patient have a diagnosis of opioid-induced constipation? ❑ **Yes** ❑ **No**
3. Is the patient receiving opioids? ❑ **Yes** ❑ **No**
4. Has the patient been evaluated and is being managed for other causes of constipation, including other diagnoses (e.g. bowel obstruction) or medications? ❑ **Yes** ❑ **No**
5. Has the patient tried and failed 2 of the following:? ❑ **Yes** ❑ **No**
   - ☐ Stimulant laxative: _____
   - ☐ Stool Softener: _____
   - ☐ Bulk forming laxative: _____
   - ☐ Osmotic laxative: _____

Non-Preferred Product *(Criteria above must also be met)*

6. Has the patient tried and failed a preferred PAMORA, per Utah Medicaid's PDL, or has the prescriber demonstrated medical necessity for a non-preferred product? ❑ **Yes** ❑ **No**
   Medication: _____ Details of Failure: _____

Reauthorization Criteria:

1. Has the provider submitted an updated letter with medical justification or updated chart notes demonstrating positive clinical response? Chart note page #: _____ ❑ **Yes** ❑ **No**

Initial Authorization: Up to six (6) months
Reauthorization: Up to one (1) year

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date