UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

PAMORAs (Movantik, Relistor, Symproic)

Peripherally acting Mu-Opioid Receptor Antagonists

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:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	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:

- ❑ Patient is 18 years or older.
- ❑ Diagnosis of opioid-induced constipation. Chart Note Page #:_____
- ❑ Patient is receiving opioids.
- ❑ Patient evaluated and is being managed for other causes of constipation, including other diagnoses (e.g. bowel obstruction) or medications.
- ❑ Trial and failure of both stimulant laxative and stool softener:

Medication/Dose	Details of Trial and Failure	Chart Note Page #
Stimulant laxative/dose:		
Stool softener/dose:		

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

- ❑ Trial and failure of preferred PAMORA, per Utah Medicaid's PDL, or prescriber must demonstrate medical necessity for non-preferred product.
  Medication: _____ Chart Note Page #: _____
  Dates of therapy: _____ Details of Failure: _____

Re-authorization criteria:

Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

Initial Authorization: Up to Six (6) months
Re-authorization: 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