



Please complete ALL information below and fax your request to 1-888-671-5285

Movantik® Prior Authorization Request Form

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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 generic substitution is acceptable <input type="checkbox"/> Check if request is for continuation of therapy		Directions for Use:

Clinical Information (required)
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 or its treatment <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
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.

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