TRICARE Prior Authorization Request Form for
plecanatide (Trulance), tenapanor hcl (Ibsrela)

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization expires after one year for the indication of chronic idiopathic constipation or IBS-C (Irritable Bowel Syndrome with Constipation). For renewal of therapy, an initial Tricare prior authorization approval is required. Prior authorization does not expire for the indication of hyperphosphatemia in CKD patients receiving dialysis.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. What is the indication or diagnosis?	☐ Hyperphosphatemia in chronic kidney disease (CKD) - Proceed to question **2** ☐ Chronic idiopathic constipation or IBS-C (Irritable Bowel Syndrome with Constipation) - Skip to question **10**	
2. What is the requested medication?	☐ Ibsrela Proceed to question **3**	☐ Other **STOP** **Coverage not approved**
3. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication prescribed by or in consultation with a nephrologist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient been receiving maintenance dialysis for at least 3 months?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the patient's serum phosphate level greater than 5.5 mg/dL and less than 10 mg/dL?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Has the patient tried and had an inadequate response to at least two phosphate binders (for example, sevelamer (Renagel, Renvela), lanthanum (Fosrenal), ferric citrate (Auryxiz), sucroferric oxyhydroxide (Velphoro), calcium carbonate, calcium acetate)?	☐ Yes **Sign and date below**	☐ No Proceed to question **8**
8. Has the patient tried and been unable to tolerate at least two phosphate binders (for example, sevelamer (Renagel, Renvela), lanthanum (Fosrenal), ferric citrate (Auryxiz), sucroferric oxyhydroxide (Velphoro), calcium carbonate, calcium acetate)?	☐ Yes **Sign and date below**	☐ No Proceed to question **9**
9. Does the patient have a contraindication to at least two phosphate binders (for example, sevelamer (Renagel, Renvela), lanthanum (Fosrenal), ferric citrate (Auryxiz), sucroferric oxyhydroxide (Velphoro), calcium carbonate, calcium acetate intolerance to any dose of phosphate binder therapy. Contraindications to phosphate binders includes bowel obstruction, iron overload, or hypercalcemia?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
10. Will the requested medication be used as dual therapy with Amitiza, Linzess, Motegrity, Symproic, Relistor, Movantik, Trulance (if the request is for Ibsrela) or Ibsrela (if the request is for Trulance)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **11**
11. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐ Yes Proceed to question **12**	☐ No Skip to question **13**
12. Has there been improvement in constipation symptoms?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
13. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Does the patient have documented symptoms for greater than or equal to 3 months?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Does the patient have gastrointestinal obstruction?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **16**
16. Is there documentation that the patient has failure with an increase in dietary fiber/dietary modification?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**

17. Has the patient tried and failed, has an intolerance or FDA-labeled contraindication to at least 2 standard laxative classes, defined as; ▪ **osmotic laxative (for example, lactulose, sorbitol magnesium [Mg] citrate, Mg hydroxide, glycerin rectal suppositories)** ▪ **bulk forming laxative (for example, psyllium, oxidized cellulose, calcium polycarbophil) with fluids** ▪ **stool softener (for example, docusate)** ▪ **stimulant laxative (for example, bisacodyl sennosides)?**	☐ Yes Proceed to question **18**	☐ No **STOP** **Coverage not approved**
18. What is the requested medication?	☐ Trulance **Sign and date below**	☐ Ibsrela **Proceed to question 19**
19. Has the patient tried and failed Linzess, Amitiza, and Trulance?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____

[29 May 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: