United Healthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 2147-7
Program	Prior Authorization/Medical Necessity
Medication	Movantik® (naloxegol)*
P&T Approval Date	7/2018, 7/2019, 8/2020, 6/2021, 6/2022, 6/2023, 6/2024
Effective Date	9/1/2024

1. Background:

Movantik (naloxegol)* and Symproic® (naldemedine) are opioid antagonists indicated for the treatment of opioid-induced constipation (OIC) in adult patients with chronic non-cancer pain including patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation. Amitiza®* (lubiprostone) is indicated for the treatment of chronic idiopathic constipation and irritable bowel syndrome with constipation in adults and for the treatment opioid-induced constipation (OIC) in adult patients with chronic, non-cancer pain, including patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation.

This prior authorization program is intended to encourage the use of lower cost alternatives. This program requires a member lower cost alternatives before providing coverage for Movantik.

2. Coverage Criteria[a]:

A. Initial Authorization

1. Movantik* will be approved based on **BOTH** of the following:

a. **ONE** of the following:

(1) Diagnosis of opioid-induced constipation with chronic, non-cancer pain

-OR-

(2) Diagnosis of opioid-induced constipation in patients with chronic pain related to prior cancer diagnosis or cancer treatment who do not require frequent (e.g., weekly) opioid dosage escalation

-AND-

b. History of failure, contraindication or intolerance to **BOTH** of the following (document date tried):

(1) lubiprostone (generic Amitiza)

-AND-

(2) Symproic

Authorization will be issued for 12 months

B. Reauthorization

1. **Movantik*** will be approved based on the following criterion:

   a. Documentation of positive clinical response to Movantik* therapy

   Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

***Brand only Amitiza and Movantik are typically excluded from coverage**

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.
- Notification/Prior Authorization may be in place.

4. References:

1. Amitiza [package insert]. Lexington, MA: Takeda pharmaceuticals America, Inc; November 2020.
2. Movantik [package insert]. Chicago, IL: Valinor Pharma, LLC; March 2023.
3. Symproic [package insert]. Raleigh, NC: BioDelivery Sciences International; July 2021.

Program	Prior Authorization/Medical Necessity – Movantik
Change Control	
Date	Change
7/2018	New program.
7/2019	Annual review. No changes.
8/2020	Annual review. Updated initial authorization and references.
6/2021	Annual review. Updated references.
6/2022	Annual review. Updated references.
6/2023	Annual review. Updated references. Removed OTC step and added step through generic Amitiza.
6/2024	Annual review. Updated background section. Added document date tried. Referenced brand Amitiza exclusion. Updated references.