

PRIOR AUTHORIZATION CRITERIA

BRAND NAME*
(generic)

MOVANTIK
(naloxegol)

Status: CVS Caremark Criteria

Type: Initial Prior Authorization

Ref # 1192-A

* Drugs that are listed in the target drug box include both brand and generic and all dosage forms and strengths unless otherwise stated. OTC products are not included unless otherwise stated.

FDA-APPROVED INDICATIONS

Movantik is 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.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for the treatment of opioid-induced constipation (OIC) in an adult patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation

RATIONALE

The intent of the criteria is to provide coverage consistent with product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines. Movantik is 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 escalations.¹

REFERENCES

1. Movantik [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; April 2020.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online, Hudson, Ohio: UpToDate, Inc.; 2021; Accessed September 2, 2021.
3. Micromedex (electronic version). IBM Watson Health, Greenwood Village, Colorado, USA. Available at: <https://www.micromedexsolutions.com>. Accessed September 2, 2021.

Written by: UM Development (CT)

Date written: 10/2014

Revised: (JH) 09/2015; 09/2016 (removed safety question); (DS) 08/2017; (JG) 09/2018 (no clinical changes); (DS) 09/2019 (no clinical changes; removed MDC); (PM) 08/2020 (no clinical changes); (DS) 09/2021 (no clinical changes)

Reviewed: Medical Affairs (DNC) 10/2014; (GAD) 09/2015, (ME) 09/2016; (LMS) 08/2017; (CHART) 09/26/2019, 09/24/2020, 09/30/2021
External Review: 12/2014, 12/2015, 12/2016, 12/2017, 12/2018, 12/2019, 12/2020, 12/2021

CRITERIA FOR APPROVAL

1	Is the requested drug being prescribed for the treatment of opioid-induced constipation (OIC) in an adult patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation?	Yes	No
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Mapping Instructions

	Yes	No	DENIAL REASONS – DO NOT USE FOR MEDICARE PART D
1.	Approve, 12 months	Deny	You do not meet the requirements of your plan. Your plan covers this drug when: - You are an adult with chronic non-cancer pain with opioid-induced constipation, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation Your request has been denied based on the information we have. [Short Description: No approvable diagnosis]