AETNA BETTER HEALTH® Coverage Policy/Guideline			
Name: Movantik			Page: 1 of 1
Effective Date: 2/3/2023			Last Review Date: 11/2022
Applies to:	☒Illinois ☒New Jersey ☒Pennsylvania Kids	☐Florida ☒Maryland ☐Virginia	☒Florida Kids ☐Michigan

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Movantik under the patient's prescription drug benefit.

Description:

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 (for example, weekly) opioid dosage escalation.

Applicable Drug List:

Movantik

Policy/Guideline:

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

AND

- The patient had treatment failure with at least one medication from the stimulant laxative group (for example, bisacodyl, sodium picosulfate, or senna)

Approval Duration and Quantity Restrictions:

Approval: 12 months

Quantity Level Limit: 30 tablets per 30 days

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.