JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Pharmacy Public** **Pharmacy Management Drug Policies**	*Policy Number*	MEDS045
		Effective Date	01/17/2024
		Approval Date	01/17/2024
	Subject **Gastrointestinal Agents - Opioid Antagonists: Movantik, Symproic, and Relistor**	*Supersedes Date*	N/A
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This document applies to the following Participating Organizations:

Priority Partners

Keywords: movantik, relistor, symproic

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I. POLICY

A. Movantik (naloxegol), Symproic (naldemedine), and Relistor (methylnaltrexone) will require prior authorization to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.
   1. PPMCO members are subject to the Priority Partners formulary, available at www.ppmco.org.
   2. USFHP members are subject to prior authorization criteria, step-edits and days-supply limits outlined in the Tricare Policy Manual. Tricare Policy supersedes JHHC Medical/Pharmacy Policies. Tricare limits may be accessed at: http://pec.ha.osd.mil/formulary_search.php?submenuheader=1

II. POLICY CRITERIA

A. **Movantik** may be approved for patients meeting the following:
   1. Patient is 18 years of age or older
   2. Documented diagnosis of opioid-induced constipation due to continuous use of a long-acting opioid agent (e.g. Oxycontin, fentanyl patches, etc.)
   3. Documented chronic non-cancer pain, including pain associated with prior cancer or its treatment, which precludes the discontinuation of the long-acting opioid agent
   4. Patient has had trial and inadequate response to both of the following:
      a. 3 or more conventional formulary laxatives for at least one month each
      b. lubiprostone therapy

B. **Symproic** may be approved for patients meeting the following:
   1. Patient is 18 years of age or older
   2. Documented diagnosis of opioid-induced constipation due to continuous use of a long-acting opioid agent (e.g. Oxycontin, fentanyl patches, etc.)
   3. Documented chronic non-cancer pain, including pain associated with prior cancer or its treatment, which precludes the discontinuation of the long-acting opioid agent
   4. Patient has had trial and inadequate response to both of the following:
      a. 3 or more conventional formulary laxatives for at least one month each

b. lubiprostone therapy

C. **Relistor Oral** may be approved for patients meeting the following:
1. Patient is 18 years of age or older
2. Documented diagnosis of opioid-induced constipation due to continuous use of a long-acting opioid agent (e.g. Oxycontin, fentanyl patches, etc.)
3. Documented chronic non-cancer pain, including pain associated with prior cancer or its treatment, which precludes the discontinuation of the long-acting opioid agent
4. Patient has had trial and inadequate response to all of the following:
   a. 3 or more conventional formulary laxatives for at least one month each
   b. lubiprostone therapy
   c. Movantik therapy
   d. Symproic therapy

D. **Relistor Subcutaneous** may be approved for patients meeting the following:
1. Patient is 18 years of age or older
2. Documented diagnosis of opioid-induced constipation due to continuous use of a long-acting opioid agent (e.g. Oxycontin, fentanyl patches, etc.)
3. Documented pain associated with an advanced illness, or active cancer
4. Patient is receiving palliative care
5. Trial and failure of 3 or more conventional formulary laxatives for at least one month each
6. Additional requirement for patients with advanced illness non-cancer pain:
   a. Trial and failure of lubiprostone, Movantik, and Symproic

III. AUTHORIZATION PERIOD/LIMITATIONS

A. Initial approval will be restricted to 6 months of therapy.
B. Approval for continuation of therapy can be extended in 12-month intervals with clinical documentation showing beneficial patient response from treatment.

IV. EXCLUSIONS

A. If the request is for a diagnosis other than opioid-induced constipation in a palliative care patient, a letter may be sent to the requesting physician to provide additional information.
B. Movantik, Symproic, and Relistor will not be approved for the following:
1. Use in the presence of bowel obstruction
2. Use for the treatment of constipation due to non-opioid causes
3. Use in pediatric patients, as safety and efficacy has not been established in patients less than 18 years of age

C. The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

V. REFERENCES

1. Movantik [prescribing information]. Wilmington, DE: Astrazeneca; 2023 March.
2. Symproic [prescribing information]. Florham Park, NJ: Shionogi Inc.; 2020 May.
3. Relistor [prescribing information]. Tarrytown, NY: Salix Pharmaceuticals; 2020 April
4. Crockett SD, Greer KB, Heidelbaugh JJ, et al. American Gastroenterological Association Institute Guideline on the Medical Management of Opioid-Induced Constipation. Gastroenterology. 2019 Jan;156(1):218-226.

VI. APPROVALS

Signature on file at JHHC

DATE OF REVISION	SUMMARY OF CHANGE
07/15/2015	Addition of Movantik, modification to package insert
03/28/2016	Updated layout
07/27/2017	Updated Exclusions section regarding physician samples
04/18/2018	Addition of Symproic
07/17/2019	Revised clinical criteria and preferred products per AGA Guidelines
08/20/2019	Clarified clinical criteria
01/20/2021	Addition of clinical criteria for subcutaneous Relistor
01/17/2024	Update clinical criteria

Review/Revision Dates: 09/01/2009, 07/15/2015, 3/28/2016, 07/27/2017, 04/18/2018, 7/17/2019, 08/20/2019, 01/20/2021, 01/17/2024