Commercial/Healthcare Exchange PA Criteria

Effective: June 3rd, 2019

Prior Authorization: Lactulose Packets

Products Affected: Lactulose 10 g Oral Packet

Covered Uses: Constipation

Exclusion Criteria: Patients who require a low galactose diet

Required Medical Information:

1. Diagnosis
2. Past medication trials

Age Restrictions: N/A

Prescriber Restrictions: N/A

Coverage Duration: 1 year

Other Criteria: Approve if the patient has met ALL of the following criteria:

1. Patient has a diagnosis of constipation; AND
2. The member must have documented intolerance or therapeutic failure to three (3) formulary alternatives used to treat constipation; AND
3. Patient must have previously documented trial and failure of ALL other covered lactulose products before the packets will be covered.

References:

1. Product Information: lactulose oral solution, lactulose oral solution. West-Ward Pharmaceuticals Corp. (per DailyMed), Eatontown, NJ, 2016.

Policy Revision history

Rev #	Type of Change	Summary of Change	Sections Affected	Date

1	New Policy	New Policy	All	6/3/2019