



Please complete ALL information below and fax your request to 1-888-671-5285

Amitiza® & Linzess® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:	Dosage Form:	
<input type="checkbox"/> Check if generic substitution is acceptable			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Chronic idiopathic constipation					
<input type="checkbox"/> Irritable bowel syndrome (IBS) with constipation					
<input type="checkbox"/> Opioid-induced constipation in adults with chronic, non-cancer pain [Amitiza only]					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Select the medications the patient has a trial and failure, contraindication, or intolerance to:					
<input type="checkbox"/> Lactulose					
<input type="checkbox"/> Polyethylene glycol					
For Amitiza requests, in addition to the above, select the medications the patient has a trial and failure, contraindication, or intolerance to:					
<input type="checkbox"/> Linzess					
<input type="checkbox"/> Movantik					
<input type="checkbox"/> Symproic					
Quantity limit requests:					
What is the quantity requested per DAY? _____					
What is the reason for exceeding the plan limitations?					
<input type="checkbox"/> Titration or loading dose purposes					
<input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)					
<input type="checkbox"/> Requested strength/dose is not commercially available					
<input type="checkbox"/> Other: _____					

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

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