

Pharmacy Prior Authorization Form

Last Reviewed: July 09

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Amitiza[®] (lubiprostone) Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

- Amitiza 8 mcg capsule
- Amitiza 24 mcg capsule

Dose: _____ Start date: _____

Priority Health Precertification Requirements:

Authorization of Amitiza requires:

- Diagnosis of Irritable bowel syndrome with constipation or chronic idiopathic constipation
- Documented therapeutic trial of Miralax **and** Lactulose

Diagnosis:

- Irritable bowel syndrome (IBS) with constipation
- Chronic idiopathic constipation
- Other: _____ Please provide rationale for use:

Patient's age: _____

Documented therapeutic trial with **all** of the following:

	Dose	Dates	Outcome
<input type="checkbox"/> Miralax	_____	_____	_____
<input type="checkbox"/> Lactulose	_____	_____	_____

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX