



Amitiza® (lubiprostone)

PRIOR AUTHORIZATION REQUEST FORM

For authorization, **please answer each question, include patient chart notes to document clinical information, and fax this form back to the PEHP Prior Authorization Department at (801) 245-7774** or mail to: PEHP Pharmacy services, 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization questions, you may phone the PEHP Customer Service at (801) 366-7551.

1. Date:	2. Patient Name:	3. ID #:
4. D.O.B:	5. Physician:	6. Office Phone:
7. Office Fax:	8. Office Contact:	9. Dose Request:
10. Sex:	11. Weight:	

Authorization is requested from: _____ to _____
Not to exceed 2 Years.

Question	Yes	No	Comments/Notes
12. What is the patient's diagnosis? <input type="checkbox"/> Chronic idiopathic constipation <input type="checkbox"/> Irritable bowel syndrome with constipation <input type="checkbox"/> Opioid-induced constipation in the setting of chronic, non-cancer pain			
13. Does the patient have a documented intolerance or an 8-week trial and failure to therapy with Linzess®?			Verification will be made by reviewing the patient's drug history or chart notes.
14. Has the patient received previous Amitiza® therapy?			
15. If 'yes' to 14, has the patient experienced improvement of constipation symptoms?			Documentation is required.

16. Physician's Signature: _____

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.