PEHP Health & Benefits

Amitiza® (lubiprostone)

PRIOR AUTHORIZATION REQUEST FORM

For authorization, **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? ☐ Chronic idiopathic constipation ☐ Irritable bowel syndrome with constipation ☐ 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: _____