

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
AMITIZA (lubiprostone)

Patient name: _____ Medicaid or SS# _____
Physician Name: _____ Contact person: _____
Phone#: _____ Ext. and opt. _____ Fax# _____
Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

FAX DOCUMENTATION FROM PROGRESS NOTES TO: 801-536-0477

CRITERIA:

- Patient must be age 18 or above
- Diagnosis of Chronic Idiopathic Constipation
Documented failure within the last 12 months using;
 - A. One fiber laxative AND
 - B. Two stimulant laxative productsDrug induced constipation must be ruled out
- Diagnosis of Irritable Bowel Syndrome with Constipation
Documented failure within the last 12 months using:
 - a. One fiber laxative AND
 - b. One osmotic laxative (magnesium salts or polyethylene glycol based laxatives)Other causes of constipation have been ruled out

AUTHORIZATION:

Chronic Constipation: 6 months

Irritable Bowel Syndrome: 3 months

RE-AUTHORIZATION:

Trial off Amitiza using other laxatives for at least 30 days

01/13/2009