

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

Patient name: _____ Medicaid ID #: _____
Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____
Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____
Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____
Requested Medication: _____ Strength: _____ Frequency/Day: _____

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

**FAX DOCUMENTATION FROM PROGRESS NOTES TO
855-828-4992 note the new fax number**

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 products
 - Drug 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 of Amitiza, using other laxatives, for at least 30 days

9/13/10

<http://health.utah.gov/medicaid/pharmacy>