OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

COMMERCIAL ONLY

Drug Requested: **Amitiza**® (lubiprostone)

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable***: _____

Chronic Idiopathic Constipation and Opioid-induced Constipation: 24mcg taken twice daily orally with food and water.

Irritable Bowel Syndrome with Constipation: 8mcg taken twice daily orally with food and water.

CLINICAL CRITERIA*: *ALL boxes below MUST be checked to qualify or authorization process will be delayed.

- **Diagnoses** *(select one from below):*
  - ❑ Chronic Idiopathic Constipation
  - ❑ Opioid-induced Constipation
  - ❑ Irritable Bowel Syndrome with Constipation
  - ❑ Other _____
- ❑ Trial and failure of Linzess® (linaclotide)
- ❑ Patient is ≥ 18 years of age

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 4/16/15
REVISED/UPDATED: ~~5/27/2015; 6/2/2015;~~ ~~12/24/2015;~~ ~~12/15/2016;~~ **8/9/2017**