



Please note: All information below is required to process this request.  
 Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern



## Amitiza® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

Clinical Information (required)	
<b>Select the diagnosis below:</b> <input type="checkbox"/> Chronic idiopathic constipation <input type="checkbox"/> Irritable bowel syndrome with constipation <input type="checkbox"/> Opioid-induced constipation <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
<b>Chronic idiopathic constipation:</b> Does the maximum daily dose exceed 24 mcg twice daily? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Irritable bowel syndrome with constipation:</b> Does the maximum daily dose exceed 8 mcg twice daily? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Opioid-induced constipation:</b> Is the patient being treated for chronic, non-cancer pain? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the maximum daily dose exceed 24 mcg twice daily? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Select if the patient has a trial and failure, contraindication, or intolerance to the following medications:</b> <input type="checkbox"/> Lactulose <input type="checkbox"/> Linzess <input type="checkbox"/> Movantik <input type="checkbox"/> Polyethylene glycol (generic Miralax) <input type="checkbox"/> Symproic	
<b>**Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.**</b> <b>*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*</b>	
<b>Prescriber Signature:</b> _____ <b>Date:</b> _____	

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.  
 For urgent or expedited requests please call 1-800-711-4555.  
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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