https://providers.amerigroup.com

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Amitiza (lubiprostone)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
Amitiza (lubiprostone)	_____	_____	Specify: _____

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- ☐ Yes ☐ No Documentation* has been provided with this request showing adequate trials and therapy failures with at least one medication from each of the following categories: Saline laxative (milk of magnesia); Osmotic laxative (polyethylene glycol or lactulose); Stimulant laxative (senna)
- ☐ Yes ☐ No Patient has a known or suspected mechanical gastrointestinal obstruction
- ☐ Yes ☐ No Patient has a diagnosis of chronic idiopathic constipation
  - ☐ Yes ☐ No Patient has less than 3 spontaneous bowel movements (SBMs) per week
  - ☐ Yes ☐ No Patient has two or more of the following symptoms within the last 3 months: straining during at least 25% of bowel movements, lumpy or hard stools for at least 25% of bowel movements, or sensation of incomplete evacuation for at least 25% of bowel movements
  - ☐ Yes ☐ No Documentation has been provided with this request showing patient is not currently taking constipation causing therapies
- ☐ Yes ☐ No Patient has a diagnosis of irritable bowel syndrome with constipation
  - ☐ Yes ☐ No Patient is female
  - ☐ Yes ☐ No Patient has abdominal pain or discomfort at least 3 days per month in the last 3 months associated with two (2) or more of the following: improvement with defecation, onset associated with a change in stool frequency, or onset associated with a change in stool form

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PATIENT NAME:_____ **PATIENT ID #:** _____

□ Yes	□ No	Patient has a diagnosis of opioid-induced constipation with chronic, non-cancer pain		
		□ Yes	□ No	Patient has been receiving stable opioid therapy for at least 30 days
		□ Yes	□ No	Patient has less than 3 spontaneous bowel movements (SBMs) per week, with at least 25% associated with one or more of the following: hard to very hard stool consistency, moderate to very severe straining, or having a sensation of incomplete evacuation
□ Yes	□ No	Patient is 18 years of age or older		
□ Yes	□ No	Request is for continuation of therapy		
		□ Yes	□ No	Documentation has been provided with this request showing adequate response to treatment

***Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.**

9. PHYSICIAN SIGNATURE

_____ _____
Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.