

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Linzess (linaclotide)
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: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient Phone #: _____ Patient Email Address: _____	Prescribing Physician: _____ Physician Address: _____ Physician Phone #: _____ Physician Fax #: _____ Physician Specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician Email Address: _____
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3. MEDICATION

4. STRENGTH

5. DIRECTIONS

6. QUANTITY PER 30 DAYS

Linzess (linaclotide)	_____	_____	Specify: _____
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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.

<input type="checkbox"/>	<input type="checkbox"/>	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)	
<input type="checkbox"/>	<input type="checkbox"/>	Patient has a known or suspected mechanical gastrointestinal obstruction	
<input type="checkbox"/>	<input type="checkbox"/>	Patient has a diagnosis of chronic idiopathic constipation	
	<input type="checkbox"/>	<input type="checkbox"/>	Patient has less than 3 spontaneous bowel movements (SBMs) per week
	<input type="checkbox"/>	<input type="checkbox"/>	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
	<input type="checkbox"/>	<input type="checkbox"/>	Documentation has been provided with this request showing patient is not currently taking constipation causing therapies
<input type="checkbox"/>	<input type="checkbox"/>	Patient has a diagnosis of irritable bowel syndrome with constipation	
	<input type="checkbox"/>	<input type="checkbox"/>	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 #:** _____

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient is 18 years of age or older
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Request is for continuation of therapy
<input type="checkbox"/> Yes	<input type="checkbox"/> 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
<i>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.</i>	
<small>Note: Payment is subject to member eligibility. Authorization does not guarantee payment.</small>	
<p>The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation.</p> <p>If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.</p>	