US Family Health Plan
Prior Authorization Request Form
for lubiprostone (**Amitiza**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization expires after one year **usfamilyhealth.org/rx-pa**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Will the requested medication be used as dual therapy with Linzess, Trulance, Symproic, Relistor, or Movantik?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **2**
2. Is the request for renewal of therapy?	☐ Yes Proceed to question **3**	☐ No Skip to question **4**
3. Has there been improvement in constipation symptoms?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
4. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **6**	☐ No Proceed to question **5**
5. Is the requested medication being prescribed by or in consultation with a pediatric gastroenterologist?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. What is the indication or diagnosis?	☐ IBS-C (Irritable Bowel Syndrome with Constipation) - Proceed to question **8** ☐ chronic idiopathic constipation - Proceed to question **9** ☐ opioid induced constipation in adults with chronic non-cancer pain Proceed to question **7** ☐ Other - **STOP Coverage not approved**	
7. Is the patient currently taking an opioid?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**

Continue on next page

8. Is the patient female?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the patient have documented symptoms for greater than or equal to 3 months?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Does the patient have documentation of failure with an increase in dietary fiber/dietary modification to relieve symptoms?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Does the patient have gastrointestinal obstruction?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Has the patient tried and failed, has an intolerance or FDA-labeled contraindication to at least 2 standard laxative classes, defined as; ▪ **osmotic laxative (e.g., lactulose, sorbitol magnesium [Mg] citrate, Mg hydroxide, glycerin rectal suppositories)** ▪ **bulk forming laxative (e.g., psyllium, oxidized cellulose, calcium polycarbophil) with fluids** ▪ **stool softener (e.g., docusate)** ▪ **stimulant laxative (e.g., bisacodyl sennosides)**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____

[15 May 2019]