

US Family Health Plan

Prior Authorization Request Form for linaclotide (**Linzess**)

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):

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

Step 2 Please complete the clinical assessment:

2	1. Will the requested medication be used as dual therapy with Amitiza, Trulance, Symproic, Relistor, or Movantik?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 2
	2. Is the request for renewal of therapy?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No Skip to question 4
	3. Has there been improvement in constipation symptoms?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
	4. Is the patient greater than or equal to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
	5. What is the indication or diagnosis? <input type="checkbox"/> IBS-C (Irritable Bowel Syndrome with Constipation) - Proceed to question 7 <input type="checkbox"/> chronic idiopathic constipation - Proceed to question 7 <input type="checkbox"/> opioid induced constipation in adults with chronic non-cancer pain Proceed to question 6 <input type="checkbox"/> Other - STOP Coverage not approved		
	6. Is the patient currently taking an opioid?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
	7. Does the patient have documented symptoms for greater than or equal to 3 months?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved

Continue on next page

<p>8. Does the patient have documentation of failure with an increase in dietary fiber/dietary modification to relieve symptoms?</p>	<p><input type="checkbox"/> Yes Proceed to question 9</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>9. Does the patient have gastrointestinal obstruction?</p>	<p><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 10</p>
<p>10. Has the patient tried and failed, has an intolerance or FDA-labeled contraindication to at least 2 standard laxative classes, defined as;</p> <ul style="list-style-type: none"> ▪ 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) 	<p><input type="checkbox"/> Yes Sign and date below</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>

Step
3

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

Prescriber Signature

Date

[15 May 2019]