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.

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 Amitiza, Trulance, Symproic, Relistor, or Movantik? How old is the patient?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **2**
2. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Linzess*	☐ Yes (subject to verification) 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. How old is the patient?	☐ Greater than or equal to 18 years of age - Proceed to question **5** ☐ Greater than or equal to 6 years of age and Less than or equal to 17 years of age - Proceed to question **11** ☐ Less than 6 years of age - **STOP Coverage not approved**	
5. What is the indication or diagnosis?	☐ IBS-C (Irritable Bowel Syndrome with Constipation) - Proceed to question **7** ☐ CIC (chronic idiopathic constipation) - Proceed to question **7** ☐ OIC (opioid induced constipation) in adults with chronic non-cancer pain - Proceed to question **6** ☐ Other - **STOP Coverage not approved**	

6. Is the patient currently taking an opioid?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Does the patient have documented symptoms for greater than or equal to 3 months?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have documentation of failure with an increase in dietary fiber/dietary modification to relieve symptoms?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the patient have gastrointestinal obstruction?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Has the patient tried and failed, has an intolerance or FDA-labeled contraindication to at least 2 standard laxative classes, defined as; ▪ **osmotic laxative (for example, lactulose, sorbitol magnesium [Mg] citrate, Mg hydroxide, glycerin rectal suppositories)** ▪ **bulk forming laxative (for example, psyllium, oxidized cellulose, calcium polycarbophil) with fluids** ▪ **stool softener (for example, docusate)** ▪ **stimulant laxative (for example, bisacodyl sennosides)**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
11. Does the patient have a diagnosis of functional constipation (FC)?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Does the patient have documented symptoms for greater than or equal to 3 months?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Has the patient tried and failed, or had an intolerance or FDA-labeled contraindication to at least 2 of these agents: lactulose, sorbitol, senna, bisacodyl, glycerin suppositories, or polyethylene glycol 3350?	☐ 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 _____

[22 Sep 2023]