**PRIORITY PARTNERS**
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

Amitiza - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Amitiza - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Amitiza (lubiprostone)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

**Diagnosis:** _____ **ICD Code:** _____

Comments: _____

**Please circle the appropriate answer for each question.**

1. Is this request for continuation of therapy? Y N

[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]

[If no, then skip to question 4.]

2. Is the patient showing beneficial response to treatment? Y N _____

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| | [Note: Documentation must be submitted.] | |
| | [If no, then no further questions.] | |
| 3. | Will the patient be using the requested drug concurrently with Linzess, Trulance, Motegrity, or Ibsrela? Y N | |
| | [No further questions.] | |
| 4. | Will the patient be using the requested drug concurrently with Linzess, Trulance, Motegrity, or Ibsrela? Y N | |
| | [If yes, then no further questions.] | |
| 5. | Is the patient 18 years of age or older? Y N | |
| | [If no, then no further questions.] | |
| 6. | Does the patient have a documented history of constipation, defined as less than three solid bowel movements (SBMs) per week for a duration of three months or greater? Y N | |
| | [Note: Documentation must be submitted.] | |
| | [If no, then skip to question 8.] | |
| 7. | Does the patient have documented trials of at least two formulary laxatives from two different therapy classes for at least one month each? Y N | |
| | [Note: Documentation must be submitted.] | |
| | [No further questions.] | |
| 8. | Does the patient have the documented diagnosis of constipation-predominant irritable bowel syndrome (IBS)? Y N | |
| | [Note: Documentation must be submitted.] | |
| | [If no, then skip to question 11.] | |
| 9. | Is the patient female? Y N | |
| | [If no, then no further questions.] | |
| 10. | Does the patient have documented trials of at least two agents to treat irritable bowel syndrome (IBS) from two different therapy classes for at least one month each? Y N | |
| | [Note: Documentation must be submitted.] | |
| | [No further questions.] | |
| 11. | Does the patient have the documented diagnosis of constipation due to continuous use of a long-acting opioid agent (Oxycontin, Fentanyl patches, etc.)? Y N | |
| | [Note: Documentation must be submitted.] | |
| | [If no, then no further questions.] | |
| 12. | Does the patient have the documented diagnosis of chronic non-cancer pain that precludes the discontinuation of the long-acting opioid agent? Y N | |
| | [Note: Documentation must be submitted.] | |
| | [If no, then no further questions.] | |

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| 13. Does the patient have documented trials and inadequate responses to Movantik, Symproic, AND Relistor? | Y N |
| [Note: Documentation must be submitted.] | |

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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| **Prescriber (Or Authorized) Signature and Date** |