



Prior Authorization
<p>JOHNS HOPKINS HEALTHCARE (MEDICAID) Amitiza Linzess Trulance Motegrity - Priority Partners MCO</p> <p>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 Healthcare at 1-410-424-4607. Please contact Johns Hopkins Healthcare at 1-888-819-1043 with questions regarding the Prior Authorization process.</p> <p>When conditions are met, we will authorize the coverage of Amitiza Linzess Trulance Motegrity - Priority Partners MCO.</p>

Drug Name (select from list of drugs shown)		
Amitiza (lubiprostone)	Linzess (linaclotide)	Lubiprostone
Motegrity (prucalopride)	Trulance (plecanatide)	
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: _____
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Comments: _____

Please circle the appropriate answer for each question.	
1. Is this request for continuation of therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N
<p>[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.]</p> <p>[If no, then skip to question 3.]</p>	
2. Is the patient showing adequate response to treatment?	<input type="checkbox"/> Y <input type="checkbox"/> N

[Note: Documentation must be submitted.]	
[No further questions.]	
3. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	
4. Is this request for Amitiza?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then skip to question 12.]	
5. 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[If no, then skip to question 7.]	
6. Does the patient have documented trials of at least two formulary laxatives from two different therapy classes for at least one month each?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[No further questions.]	
7. Does the patient have the documented diagnosis of constipation-predominant irritable bowel syndrome (IBS)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[If no, then skip to question 9.]	
8. 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[No further questions.]	
9. Does the patient have the documented diagnosis of constipation due to continuous use of a long-acting opioid agent (oxycontin, fentanyl patches, etc.)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
10. Does the patient have the documented diagnosis of chronic non-cancer pain that precludes the discontinuation of the long-acting opioid agent?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
11. Does the patient have documented trials and inadequate responses to Movantik, Symproic, AND Relistor?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[No further questions.]	
12. Is this request for Linzess or Trulance?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then skip to question 14.]	

13. Does the patient have the documented diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome (IBS) with constipation?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[If yes, then skip to question 16.]	
[If no, then no further questions.]	
14. Is this request for Motegrity?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	
15. Does the patient have the documented diagnosis of chronic idiopathic constipation (CIC)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
16. Does the patient have a documented trial of Amitiza?	<input type="checkbox"/> Y <input type="checkbox"/> 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.

Prescriber (Or Authorized) Signature and Date