

Prior Authorization Request Form for linaclotide (Linzess)



JOHNS HOPKINS
M E D I C I N E

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HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

**FAX Completed Form and
Applicable Progress Notes to:
(410) 424-4037**

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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:

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? Please choose "NO" if the patient did not previously have a Tricare approved PA for Linzess	<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

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8. Does the patient have documentation of failure with an increase in dietary fiber/dietary modification to relieve symptoms?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved
9. Does the patient have gastrointestinal obstruction?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> 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; <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) 	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

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

**Step
3**

 Prescriber Signature

 Date

[15 May 2019]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____ month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: