West Virginia Medicaid
Drug Prior Authorization Form

http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx

Amitiza® (lubiprostone) Prior Authorization Form

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last) | (First) | (M) | WV Medicaid 11 Digit ID# | Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) | (First) | (MI)

Prescriber Address (Street) | (City) | (State) | (Zip)

(State): West Virginia

Prescriber 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) | (City) | (State) | (Zip)

(State): West Virginia

Pharmacy 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Drug Name: lubiprostone (Amitiza®)

Strength: ☐ 8 mcg ☐ 24 mcg

Route of Administration

Directions | Diagnosis | ICD Diagnosis Code (if available)

Is there a diagnosis of Chronic Idiopathic Constipation, with less than three spontaneous bowel movements per week?	☐ Yes - proceed to next section	☐ No - proceed to next question
Is the patient female with a diagnosis of Irritable Bowel Syndrome with Constipation (IBS-C)?	☐ Yes - proceed to next section	☐ No - proceed to next question
Is there a diagnosis of opioid induced constipation accompanied by a diagnosis of non-cancer chronic pain? (Diagnosis of chronic pain must be documented with diagnostic studies, if appropriate)	☐ Yes - proceed to next section	☐ No - request is not approved

Is the patient eighteen (18) years of age or older?	☐ Yes	☐ No - not approved	Is there documentation of failure of an increase in dietary fiber/dietary modification?	☐ Yes	☐ No - not approved
Has the patient tried and failed at least fourteen (14) days of therapy **each** with osmotic and bulk forming laxatives?	☐ Yes - List Below	☐ No - not approved			
Osmotic Laxative Product			Dates of trial period:		
Bulking Laxative			Dates of trial period:		

Has the patient been screened for colon cancer, history of bowel obstruction, hepatic or renal disease, hypothyroidism, pelvic floor abnormalities and spinal cord abnormalities?	☐ Yes	☐ No - not approved			
Document whether or not the following disease states are present:					
Renal impairment	☐ Yes	☐ No	Moderate or severe hepatic impairment	☐ Yes	☐ No
History of bowel obstruction	☐ Yes	☐ No	Suspected sphincter of Oddi dysfunction	☐ Yes	☐ No
Symptomatic gallbladder disease	☐ Yes	☐ No	Known hypersensitivity to the drug or its excipients	☐ Yes	☐ No
Abdominal adhesions	☐ Yes	☐ No			

Other Pertinent Information.

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

☐ Check here for electronic signature

Prescriber or Pharmacist Signature

Date: (MM/DD/YYYY)