West Virginia Medicaid
Drug Prior Authorization Form

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

Prior Authorization Form
Amitza® (lubirprostone)
Linzess® (linaclotide)

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
Amitiza® (lubiprostone)
Strength
☐ 8 mcg ☐ 24 mcg

Drug Name
Linzess® (linaclotide)
Strength
☐ 145 mcg ☐ 290 mcg

Route of Administration | Directions

ICD Diagnosis Code (if available) | Diagnosis

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 there a diagnosis of Irritable Bowel Syndrome with Constipation (IBS-C)?	☐ 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 with osmotic laxatives?				☐ Yes - List Below	☐ No - not approved
Osmotic Laxative Product			Dates of trial period:		

Has the patient been screened for each of the following:					
Colon Cancer	☐ Yes	☐ No	History of bowel obstruction	☐ Yes	☐ No
Hepatic disease	☐ Yes	☐ No	Renal disease	☐ Yes	☐ No
Hypothyroidism	☐ Yes	☐ No	Pelvic floor abnormalities	☐ Yes	☐ No
Spinal cord abnormalities	☐ Yes	☐ No			

If no, PA will not be approved. If yes to any of the above, please explain the significance of the finding and/or any prior therapy attempted.

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)