Amitiza® Prior Authorization Request Form

Please fax the completed request form to the Coventry Health Care Pharmacy Department at 877-815-8751. For additional information please call 800-647-2240.

Patient Name: ____ Today's Date: _____/_______/_______

Patient Pharmacy ID: ___________________________________ Date of Birth: _____/_______/________

(located on bottom right of insurance card)

Requesting Physician: __________________________________ Specialty: _________________________

(Please print)

Office Contact Person: _________________________________ Phone #: (_____)_____-______ext____

Office Address: ____

Medication/dose Requested: ______________________________ Fax #: __(______)______-___________

Expected Duration of Therapy: ___________________________ ICD-9 ____________________________

1. Gender (circle) Male Female
2. Does the patient have a diagnosis of Irritable Bowel Syndrome (IBS)? YES NO
3. Is the main symptom of IBS constipation? YES NO
4. Is the abdominal pain/discomfort associated with any of the following: YES NO
   - ____ Relieved with defecation
   - ____ Change in stool frequency
   - ____ Change in stool consistency
5. Does the patient experience two or more of the following at least 2 days/week? YES NO
   - ____ Altered stool frequency (greater than 3 bowel movements per day)
   - ____ Altered stool form (lumpy/hard or loose/watery)
   - ____ Passage of mucus
   - ____ Bloating or feeling of abdominal distension
6. Does the patient have a diagnosis of chronic idiopathic constipation? YES NO
7. Does the patient have some other diagnosis for which you are requesting Amitiza? YES NO
   Diagnosis ______________________________
8. Has the patient had documented failure with over-the-counter (OTC) items and Formulary medication(s) at appropriate doses? YES NO

Medication	Dose	Date	Therapeutic Outcome
Psyllium (Metamucil or Citrucel)			
Colace, Dulcolax, Senokot			
Lactulose (Constulose, Enulose, or Kristalose)			
Other -			

9. Does patient have any of the following? (Please mark all that apply) YES NO
   - ____ Severe renal impairment
   - ____ Moderate or severe hepatic impairment
   - ____ History of bowel obstruction
   - ____ Symptomatic gallbladder disease
   - ____ Abdominal adhesions
   - ____ Suspected sphincter of Oddi dysfunction
   - ____ Known hypersensitivity to tegaserod or any of the product excipients

Physician's Signature: ____________________________________ Date: _____/_______/_____

For Mercy Health Plans use only:

☐ Approved Length of Approval ___________________________

☐ Denied Reason for Denial ____

Reviewer's Signature: ____________________________________ Date Reviewed: _____/______/_____

Override Entered in ☐ Caremark ☐ CCMS for _________-__________by____________________

Created: 05/31/2005; Updated: 05/01/2011