2014 LINZESS PRIOR AUTHORIZATION FORM-

Use for Advantra CCP Premier, Advantra CCP Premier Plus, Advantra CCP Secure Plus, CHC of Florida, First Health Part D Premier Plus formularies

Coverage Criteria: *Diagnosis for use: For the treatment of irritable bowel syndrome with constipation (IBS-C) OR for the treatment of chronic idiopathic constipation. Requests for chronic idiopathic constipation will be covered following a trial and failure or contraindication to both polyethylene glycol AND lactulose.*
Quantity limit*: 30 units per 30 days*
Authorization Period: 1 year

PLEASE FAX COMPLETED FORM TO: 1 (800) 639-9158

********Please note any information that is incomplete or illegible will delay the review process.********

Patient Name:	**Member ID #**
******Member Phone Number******	
Plan ID:	**Benefit:**
Date of Request:	**DOB:**
Requesting Physician:	**DEA #**
Office Phone #	**Office Fax #**
Office Address:	
Tax ID Number:	

MEDICATION INFORMATION

1.	Drug Requested: ☐ Linzess		
2.	Please list strength and frequency requested:		
3.	Diagnosis: ☐ IRRITABLE BOWEL SYNDROME W. CONSTIPATION ☐ CHRONIC IDIOPATHIC CONSTIPATION: ☐ OTHER:_____		
6.	**CURRENT/PAST MEDICATIONS USED**	**DATES OF TREATMENT**	**THERAPEUTIC OUTCOME**
7.	**Additional Comments:**		
8.	**Physician signature (and specialty if applicable):_____**		

For Urgent Requests please call (800) 551-2694
Visit our Websites at http://www.firsthealthpartd.com, http://www.chcadvantra.com, http://www.summithealthplan.com and http://www.vistahealthplan.com

Please complete this section only if your patient does not meet the standard requirements listed above.

Please explain why your patient should be considered for exception although not meeting the plans suggested PA criteria. Statement should include specifically which requirement is not met and why patient should be exempt from meeting this requirement.

(Please note any information that is incomplete or illegible will delay the review process)

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CHCH 11/2013

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