AMITIZA (lubiprostone)

PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark's prior authorization department at 1-888-836-0730. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures. Members should call Caremark Customer Care at 1-888-963-7290 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. Is the patient 18 years of age or older? Y N
2. Does the patient have a diagnosis of chronic constipation? Y N
3. Is the constipation due to other diseases or drugs? Y N
4. Does the patient have a history of mechanical gastrointestinal obstruction? Y N
5. Does the patient have a diagnosis of severe diarrhea? Y N
6. Is the patient female? Y N

   [If the answer to this question is no, then no further questions are required.]
7. Is the patient of child bearing potential? Y N

   [If the answer to this question is no, then no further questions are required.]
8. Has pregnancy been excluded as confirmed by a negative urine or serum pregnancy test? Y N
9. Is the patient capable of complying with effective contraceptive measures? Y N

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10. [No further questions required.]

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date: