



Amitiza® Prior Authorization Request Form

Please fax the completed request form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 800-466-9854. For additional information please call 314-214-8501 or 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 #: _____
 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 _____

Office Notified on _____; at _____ am/pm; by _____ spoke to _____