



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 314-2148282 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 #: (____)____-____ 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 Zelnorm? 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 _____