OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Amitiza® & Linzess® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
- ❑ Chronic idiopathic constipation
- ❑ Irritable bowel syndrome (IBS) with constipation
- ❑ Opioid-induced constipation in adults with chronic, non-cancer pain [**Amitiza** only]
- ❑ Opioid-induced constipation in patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation [**Amitiza** only]
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Select the medications the patient has a trial and failure, contraindication, or intolerance to:
- ❑ Lactulose
- ❑ Polyethylene glycol (Please specify date of trial): Date:_____

For Amitiza requests, in addition to the above, select the medications the patient has a trial and failure, contraindication, or intolerance to:
- ❑ Linzess
- ❑ Movantik
- ❑ Symproic (Please specify date of trial): Date:_____
- ❑ Other OTC medication (Please specify medication and date of trial): Medication:_____ Date:_____

Reauthorization request:

For reauthorization requests, also answer the following:

Is there documentation of positive clinical response to therapy? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?
- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.