TEXAS MEDICAID
Clinical Edit Prior Authorization
lubiprostone (AMITIZA)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:
STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

STEP 3: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of irritable bowel syndrome in the last 365 days?

   ☐ Yes (Go to #3) ☐ No (Go to #4)

3. Is the client a female?

   ☐ Yes (Go to #7) ☐ No (Deny)

4. Does the client have a diagnosis of chronic idiopathic constipation in the last 365 days?

   ☐ Yes (Go to #7) ☐ No (Go to #5)

5. Does the client have a diagnosis of opioid-induced constipation with chronic, non-cancer pain in the last 365 days? ☐ Yes (Go to #6) ☐ No (Deny)
6. Does the client have a 14-day supply of opiates in the last 30 days? ☐ Yes (Go to #7) ☐ No (Deny)
7. Does the client have a history of a gastrointestinal (GI) obstruction in the last 730 days? ☐ Yes (Deny) ☐ No (Go to #8)
8. Is the quantity being requested less than or equal to (≤) 2 capsules per day? ☐ Yes (Approve – 365 days) ☐ No (Deny)
STEP 4: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**
Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.