



Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization

Gastrointestinal (GI) Motility Agents: linaclotide (LINZESS)

Request Information (required)

This request is:

- Expedited* (Urgent)**
 Standard (Non-Urgent)

*Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)

Prescriber Information (required)

Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :		Specialty:
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

Clinical Criteria (required)

6. Is the member greater than or equal to (\geq) 18 years of age?

Yes
(Go to #7)

No
(Go to #8)

7. Does the member have a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome (IBS) in the last 365 days?

Yes

(Go to #10)

No (Deny)

(Go to #8)

8. Is the member greater than or equal to (\geq) six (6) years and less than ($<$) 18 years of age?

Yes

(Go to #9)

No (Deny)

(Go to #9)

9. Does the member have a diagnosis of functional constipation in the last 365 days?

Yes

(Go to #10)

No (Deny)

(Go to #10)

10. Does the member have a history of gastrointestinal (GI) obstruction in the last 730 days?

Yes (Deny)

(Go to #11)

No

(Go to #11)

11. Is the quantity being requested less than or equal to (\leq) one (1) capsule per day?

Yes (Approve - 365 days)

(Go to #12)

No (Deny)

(Go to #12)

Additional Information

12. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

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If criteria not met, submit chart documentation with form citing complex medical circumstances.
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