Prior Authorization Form

Molina Healthcare of Texas

Amitiza (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Amitiza (Medicaid).

Drug Name (select from list of drugs shown)	
Amitiza 8mcg Capsules	Amitiza 24mcg Capsules

Patient Information	
Patient Name:	
Patient ID:	
Patient Group No.:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:

Please circle the appropriate answer for each question.

1. Is the patient greater than or equal to (≥) 18 years of age? ☐ Y ☐ N
   If the answer to this question is yes, skip to question 2.
   If the answer to this question is no, denied.

2. Does the patient have a diagnosis of irritable bowel syndrome in the last 365 days? ☐ Y ☐ N
   If the answer to this question is yes, skip to question 3.
   If the answer to this question is no, go to question 4.

3. Is the patient a female? ☐ Y ☐ N
   If the answer to this question is yes, skip to question 5.
   If the answer to this question is no, denied.

4. Does the patient have a diagnosis of chronic idiopathic constipation or opioid-induced constipation with chronic, non-cancer pain in the last 365 days? ☐ Y ☐ N
   If the answer to this question is yes, skip to question 5.
   If the answer to this question is no, denied.

5. Does the patient have a history of gastrointestinal (GI) obstruction in the last 730 days? ☐ Y ☐ N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 6.

6. Does the patient have a history of Amitiza in the past 45 days? ☐ Y ☐ N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 7.

7. Is the quantity being requested less than or equal to (≤) 2 caps/day? ☐ Y ☐ N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date