Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Linzess

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Linzess.
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Linzess (linaclotide)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Is the patient 18 years of age or older? Y N
   [If no, then no further questions.]
2. Has documentation been submitted from a digestive disease specialist? Y N
   [If no, then no further questions.]
3. Does the patient have a diagnosis of chronic idiopathic (from an unknown cause) constipation? Y N
   [If no, then skip to question 8.]

4. Has the patient had a trial and failure of over the counter laxatives (including Miralax [polyethylene glycol 3350]) and lactulose (a prescription medication) within the past month? [If no, then no further questions.] Y N

5. Does the patient have less than three spontaneous (without laxative) bowel movements per week? [If no, then no further questions.] Y N

6. Has the patient had at least a recent three month history (which need not be consecutive) of very hard stools, sensation of incomplete evacuation or straining with defecation (constipation)? [If yes, then no further questions.] Y N

7. Has the provider attempted to treat constipation related to a known cause by correcting the known cause (i.e., reducing or discontinuing opioid medication)? [No further questions.] Y N

8. Does the patient have a diagnosis of IBS with constipation? [If no, then no further questions.] Y N

9. Does the patient have a mean abdominal pain score of at least 3 on a 0-to-10-point numeric rating scale? [If no, then no further questions.] Y N

10. Has the patient had recurring or consistent episodes of less than 3 complete spontaneous bowel movements per week within the past six months? Y N

Comments:

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

Prescriber (Or Authorized) Signature Date