



Date \_\_\_\_\_

Client \_\_\_\_\_

### PRIOR AUTH QUESTIONNAIRE-AMITIZA®

<i>M.D. Last Name:</i> _____	<i>M.D. First Name:</i> _____
<i>Physician Phone:</i> _____	<i>Physician Fax:</i> _____
<i>Patient</i> _____	<i>ID#</i> _____ <i>DOB</i> _____

**\*\*FAILURE TO COMPLETE THE FORM MAY RESULT IN AN AUTOMATIC DENIAL\*\***

1. Diagnosis:
  - Chronic idiopathic constipation
  - Irritable bowel syndrome with constipation in women
  - Other (please specify): \_\_\_\_\_
2. Does the patient have a known or suspected mechanical gastrointestinal obstruction? Yes    No
3. Does the patient have any known hypersensitivity to lubiprostone or any of its excipients? Yes    No
4. Does the patient have severe diarrhea? Yes    No
5. Is the patient 18 years of age or older? Yes    No
6. Has the patient tried and failed a lactulose-based product (Constulose, Enulose, Kristalose)? Yes    No
  - a. If Yes, specify drug and dates of trial \_\_\_\_\_
  - b. If No, provide the rationale for non-trial \_\_\_\_\_
7. Has the patient tried and failed a PEG 3350-based product (Miralax, Glycolax)? Yes    No
  - a. If Yes, specify drug and dates of trial \_\_\_\_\_
  - b. If No, provide the rationale for non-trial \_\_\_\_\_
8. Physician Signature or name of person providing answers \_\_\_\_\_

Physician Comments \_\_\_\_\_

Send or Fax completed form to:  
**877-329-7279**

RESTAT  
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Milwaukee, WI 53224

QUESTIONS PLEASE CALL:  
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