



Date _____

Client _____

PRIOR AUTH QUESTIONNAIRE-AMITIZA®

M.D. Last Name: _____ *M.D. First Name:* _____

Physician Phone: _____ *Physician Fax:* _____

Patient _____ *ID#* _____ *DOB* _____

****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
P.O. BOX 758
WEST BEND, WI 53095

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