

# Amitiza<sup>®</sup> (lubiprostone)



An Independent Licensee of the Blue Cross and Blue Shield Association

## Prior Authorization Request (Physician to Complete)

Visit [www.wellmark.com](http://www.wellmark.com) for the Wellmark Drug List for current medication tier levels and updated PA Forms

### Facsimile Transmittal Sheet

Date: \_\_\_/\_\_\_/\_\_\_

To: Wellmark Pharmacy Services

From (Prescriber's Name): \_\_\_\_\_

Fax Number: (866) 884-4345

Prescriber's DEA Number: \_\_\_\_\_

Phone Number: (800) 600-8065

Prescriber's Phone Number: \_\_\_\_\_

Prescriber's Specialty: \_\_\_\_\_ Prescriber's Fax Number: \_\_\_\_\_

Prescriber's Office Address: \_\_\_\_\_  
Street Suite # City State Zip

Patient Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_ Patient DOB: \_\_\_/\_\_\_/\_\_\_

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. Provide the diagnosis this therapy has been prescribed for: \_\_\_\_\_

2. Patient gender?  Female  Male

3. Patient age (at time of request)? \_\_\_\_\_

4. Is this an initial request or a continuation of therapy?  Initial  Continuation

If a continuation of therapy, has the patient responded to therapy?  Yes  No

5. Frequency of bowel movement: \_\_\_\_\_ per \_\_\_\_\_

6. Provide a list of the medication(s) this patient has tried:

_____	_____
_____	_____
_____	_____
_____	_____

7. Drug Strength: \_\_\_\_\_ mg

Drug Frequency: \_\_\_\_\_ capsules per \_\_\_\_\_

Printed Name

Signature

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