

**CRITERIA FOR PRIOR AUTHORIZATION**

Constipation Agents

**PROVIDER GROUP** Pharmacy

**MANUAL GUIDELINES** The following drugs requires prior authorization:  
Linaclotide (Linzess®)  
Lubiprostone (Amitiza®)

**CRITERIA FOR CONSTIPATION AGENTS (Must meet the following criteria):**

- Patient must have one of the following diagnoses:
  - chronic idiopathic constipation
  - irritable bowel syndrome (IBS) with constipation
  - opioid-induced constipation with chronic, non-cancer pain (**Amitiza Only**)
- Patient must be 18 years of age or older
- Patient must have a trial and failure of or intolerance to lactulose or polyethylene glycol (PEG-3350) for at least 90 days

**LENGTH OF APPROVAL** 12 months

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR

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PHARMACY PROGRAM MANAGER  
DIVISION OF HEALTH CARE FINANCE  
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

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