



**Kansas Medical Assistance Program**

P O Box 3571  
Topeka, KS 66601-3571  
Provider 1-800-933-6593  
Beneficiary 1-800-766-9012

**Step Therapy Prior Authorization for Constipation Agents:  
Linzess® (Linaclotide) or Amitiza® (Lubiprostone)**

**Beneficiary Information**

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

Medicaid ID #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Pharmacy Information**

Name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_

NPI #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Requested Drug: \_\_\_\_\_ NDC: \_\_\_\_\_

**Prescriber Information**

Name: \_\_\_\_\_ Medicaid ID # \_\_\_\_\_

NPI #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Please provide the required information to receive the requested medication.

**1. Diagnosis:**

- Chronic Idiopathic Constipation
- Irritable Bowel syndrome (IBS) with constipation
- Opioid-induced constipation with chronic, non-cancer pain (Amitiza only)

**2. Previous Constipation Agents History:**

Lactulose for at least 90 days

- Trial and Failure
- Intolerance

**OR**

Polyethylene glycol (PEG-3350) for at least 90 days

- Trial and Failure
- Intolerance

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**The completed form should be faxed to the HP Prior Authorization Unit at 1-800-913-2229.  
This form will be returned unprocessed if it is not completed in its entirety.**