



Kansas Medical Assistance Program

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

**Constipation agents
Linzess® (linaclotide), Amitiza® (lubiprostone)
Prior Authorization Request Form**

Beneficiary Information

Name: _____

Medicaid ID #: _____ Date of Birth: _____

Billing Provider Information (Pharmacy, Physician, or Facility)

Name: _____ Medicaid ID #: _____

NPI #: _____ Phone #: _____ Fax #: _____

Requested Drug: _____ NDC: _____

Requested Procedure Code (if applicable) _____ Total # of Units Requested (per 6 months) _____

Prescriber Information

Name: _____ Medicaid ID #: _____

NPI #: _____ Phone #: _____ Fax #: _____

Requested Information

1. Please indicate the diagnosis for which Amitiza or Linzess is being prescribed:

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.**