



AETNA BETTER HEALTH®  
Coverage Policy/Guideline

Name: Linzess

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Effective Date: 2/11/2026

Last Review Date: 1/2026

Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input type="checkbox"/> Florida Kids
	<input checked="" type="checkbox"/> New Jersey	<input type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	<input type="checkbox"/> Kentucky PRMD

### Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Linzess under the patient's prescription drug benefit.

### Description:

Linzess is indicated for the treatment of:

- Irritable bowel syndrome with constipation (IBS-C) in adults and pediatric patients 7 years of age and older
- Chronic idiopathic constipation (CIC) in adults
- functional constipation (FC) in pediatric patients 6 years of age and older

### Applicable Drug List:

Linzess

### Policy/Guideline:

The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for the treatment of irritable bowel syndrome with constipation (IBS-C) in adult and pediatric patients 7 years of age or older

**AND**

- For a biological female or a person that self-identifies as a female who is 18 years of age or older, a trial and inadequate treatment response, intolerance, or a contraindication to lubiprostone is required.

**AND**

- The patient had treatment failure with ONE of the following classes: a bulk forming laxative (psyllium or fiber) or an osmotic laxative (for example, PEG)

**OR**

- The requested drug is being prescribed for the treatment of chronic idiopathic constipation (CIC) in an adult

**AND**

- The patient had treatment failure with ONE of the following classes: a bulk forming laxative (psyllium or fiber), an osmotic laxative (for example, PEG) or a stimulant laxative (bisacodyl, sodium picosulfate [SPS] or senna)

**AND**



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- The patient has had a trial and inadequate treatment response, intolerance, or a contraindication to ONE of the following: lubiprostone OR prucalopride

**OR**

- The requested drug is being prescribed for the treatment of functional constipation (FC) in a pediatric patient 6 years of age or older

**AND**

- The patient has had a trial and inadequate treatment response, intolerance, or a contraindication to:
  - an osmotic laxative (for example: polyethylene glycol (Miralax), lactulose, magnesium hydroxide (milk of magnesia)
- a stimulant laxative (for example: bisacodyl, senna)

**Approval Duration and Quantity Restrictions:**

**Approval:** 12 months

**Quantity Level Limit:** 30 tablets per 30 days

**References:**

1. Linzess [package insert]. North Chicago, IL: AbbVie, Inc.; Boston, MA: Ironwood Pharmaceuticals, Inc.; November 2025.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2025. <https://online.lexi.com>. Accessed August 11, 2025.
3. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: <https://www.micromedexsolutions.com/> (cited: 08/11/2025).