

Pharmacy

PRIOR AUTHORIZATION FORM

Last Reviewed: November 2011

New: November 2010

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Relistor[®] (methylnaltrexone)

URGENT (life threatening)

Non-Urgent (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

Provider Signature

Date

PRODUCT INFORMATION

Relistor[®] 12mg/0.6mL Solution for Injection

Number of Doses: _____

Patient Weight: _____

BILLING INFORMATION

Place of administration:

- Provider's Office
 Outpatient Infusion Center
Center Name: _____
 Home Infusion
Agency Name: _____
 Self Administration

Billing Options:

- Physician buy and bill
 Preferred Specialty Vendor
 Other: _____

Request:

- New
 Continuation

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for Relistor[®] (methylnaltrexone) requires the following information to certify:

Patient must meet the following medical risk factors:

- Diagnosis of opioid-induced constipation
 - Note: off-label uses of Relistor[®] will not be approved.
- Patient is receiving palliative care with advanced illness (life expectancy less than 6 months)
- Patient is unresponsive with a minimum of 2 other laxative therapies or unable to tolerate oral laxatives
- Patient must be free of mechanical gastrointestinal obstruction, an indwelling peritoneal catheter, clinically active diverticular disease, fecal impaction, acute surgical abdomen, and fecal ostomy.

NOTE: Initial authorization will be for 3 injections (1 injection every 48 hours). For patients not responsive to initial therapy, second and subsequent authorizations will be authorized for 7 injections with no more than 3 repeats. For patients responsive to initial therapy, authorization will be for 7 injections per request with no repeat limits.

SECTION A - NEW REQUEST

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for Relistor[®] (methylnaltrexone) requires the following information to certify:

- A. Patient is diagnosed with opioid-induced constipation.
- a. Yes – ICD code: _____
 - b. No – Rationale for use: _____
- B. Patient is in palliative care
- C. Patient has a life expectancy of less than 6 months
- D. Patient has not responded to, at minimum, two other laxative therapies:
- a. Drug _____ Length of therapy _____
 - b. Drug _____ Length of therapy _____
- or
- c. Patient is unable to tolerate oral laxative therapy
- E. Mark any of the following that apply to the patient (*authorization will be denied*):
- a. Mechanical gastrointestinal obstruction
 - Indwelling peritoneal catheter
 - Clinically active diverticular disease
 - Fecal impaction
 - Acute surgical abdomen
 - Fecal ostomy
- b. None of the above apply to this patient.

NOTE: Initial authorization is limited to 3 injections (1 injection every 48 hours). For patient needing additional therapy, a continuation request must be authorized.

SECTION B - CONTINUATION**PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION**

Authorization for continuation of Relistor[®] (methylnaltrexone) requires the following information to certify:

- A. Patient remains in palliative care with opioid-induced constipation
- B. Patient has demonstrated a response to methylnaltrexone
(an additional 7 injections will be authorized)
- Patient has **not** demonstrated a response to methylnaltrexone and a repeat attempt is being made to produce laxation (Note: a maximum of 3 repeats will be authorized for a quantity of 7 injections each)
- a. Second attempt
 - b. Third attempt
 - c. Fourth attempt
 - d. Fifth attempt (*authorization will be denied*)

*** All fields must be complete and legible for Prior Authorization Review***

Please fax this request to: (877)974-4411 toll free or (616)942-8206

YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX