

Pharmacy

PRIOR AUTHORIZATION FORM

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: _____

Coverage Duration: When authorized, Relistor is approved for 4 months.

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: _____

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
- 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

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. Does the patient have a mechanical gastrointestinal obstruction?
- No
- Yes – Rationale for use: _____

PRIORITY MEDICARE PLANS

Note: Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

FOR MEDICARE ONLY

If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

- All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
- The number of doses available under a dose restriction for the prescription drug:
 - Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
- The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
 - Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
 - Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
- None of the above apply

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX