PriorityHealth

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Relistor® (methylnaltrexone)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Phys. Phone: _____ Phys. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

Drug product: ☐ Relistor 12 mg/0.6 mL injection

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____
Patient's weight: _____
How many doses are needed? _____

Place of administration:
☐ Physician's office
☐ Outpatient infusion
Facility: _____ NPI: _____ Fax: _____
☐ Home infusion
Facility: _____ NPI: _____ Fax: _____

Billing:
☐ Physician to buy and bill
☐ Facility to buy and bill
☐ Specialty Pharmacy
Pharmacy: _____ NPI: _____ Fax: _____

ICD-10 Diagnosis code(s): _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of opioid-induced constipation
2. Patient must first try two other laxative drugs, or be unable to tolerate oral laxatives AND
3. Therapeutic trial of Movantik or Symproic
4. Patient must not have a mechanical gastrointestinal obstruction, indwelling peritoneal catheter, clinically active diverticular disease, fecal impaction, acute surgical abdomen, or fecal ostomy

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 11/2014
Last reviewed 11/2018

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Additional information

Authorization will only be approved for 4 months maximum, as evidence to support use beyond that is not available.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

New request

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Opioid-induced constipation
- ☐ Other – the patient's condition is: _____

Rationale for use: _____

B. What other laxatives has the patient tried?

Drug name: _____

Drug name: _____

Drug name: _____

C. The patient has had a therapeutic trial of Movantik?

- ☐ Yes
- ☐ No, Rationale for use: _____

D. Which, if any, of the following conditions does the patient have?

- ☐ Mechanical gastrointestinal obstruction
- ☐ Indwelling peritoneal catheter
- ☐ Clinically active diverticular disease
- ☐ Fecal impaction
- ☐ Acute surgical abdomen
- ☐ Fecal ostomy
- ☐ None of the above apply to this patient

Continuation request

Priority Health Precertification Documentation

A. Is the patient in palliative care with opioid-induced constipation?

☐ Yes ☐ No

B. Has the patient responded to previous Relistor injections?

☐ Yes ☐ No

C. For patients that have not yet responded to prior injections, how many attempts have been made?

- ☐ This request is for the second attempt
- ☐ This request is for the third attempt
- ☐ This request is for the fourth attempt
- ☐ This request is for the fifth attempt
- ☐ More than 5 attempts have been made and the patient has not responded to Relistor

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Last reviewed 11/2018