Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Relistor® (methylnaltrexone)

Member

Last Name: _____ First Name: _____
ID #: _____ DOB: _____ Gender: _____
Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
Provider Address: _____
Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

Drug product:
☐ Relistor 12 mg/0.6 mL injection
☐ Relistor tablet

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

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

1. Must be used for a medically-accepted indication*
2. Patient must be unresponsive to a minimum of 2 other laxative drugs or be unable to tolerate oral laxatives
3. Patient must not have a mechanical gastrointestinal obstruction

Additional information

Note: If approved, the coverage duration for Relistor is 4 months.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2018
Last reviewed 11/2018

Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

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

B. What other laxatives has the patient tried?

Drug name: _____
Drug name: _____
Drug name: _____

C. Does the patient have a mechanical gastrointestinal obstruction?

☐ Yes ☐ No

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Relistor likely be the most effective option for this patient?

☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

If the patient is currently using Relistor, would changing the patient's current regimen likely result in adverse effects for the patient?

☐ Yes ☐ No
If yes, please explain: _____

_____

_____

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Last reviewed 11/2018