PriorityHealth

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

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New request ☐ Continuation request

Drug product: ☐ Relistor 150mg tablets

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

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 (one of which includes lactulose) or be unable to tolerate oral laxatives, **AND THEN**
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

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: _____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 11/2016
Last reviewed 11/2019

B. What other laxatives has the patient tried?

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

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

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Last reviewed 11/2019