

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

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

Additional information

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: _____	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