carolina complete health

Selective Constipation Agents PA Request Form (Relistor)

Member Information

1. Member Last Name:_____ 2. First Name:_____

3. Member ID #:_____ 4. Member Date of Birth:_____ 5. Member Gender:_____

Prescriber Information

6. Prescribing Provider NPI#:_____

7. Requester Contact Information Name:_____ Phone #:_____ Ext:_____

Drug Information

8. Med requested:_____ Relistor Tablet_____ Relistor Syringe/Vial

9. Quantity per 30 days_____ 9a. Duration_____

For Coverage of Relistor Tablet (*For continued therapy please submit documentation that indicates the member has had an improvement in their symptoms from baseline.)*

10. Does the member have a diagnosis of opioid-induced constipation with chronic non-cancer pain (including patients w/ chronic pain related to prior cancer or its treatment who do not require frequent opioid dosage escalation)? Yes☐ No☐

11. Is the member's age 18 or older? Yes☐ No☐

12. Does the member have a known or suspected mechanical gastrointestinal obstruction? Yes☐ No☐

13. Has the member received opioids for at least 4 weeks duration? Yes☐ No☐

14. Has the member tried and failed Amitiza AND Movantik? Yes☐ No☐

15. Does the member have a contraindication, or intolerance to Amitiza AND Movantik? Yes☐ No☐

Please list: _____

For Coverage of Relistor Syringe/Vial (*For continued therapy please submit documentation that indicates the member has had an improvement in their symptoms from baseline.)*

16. Does the member have a diagnosis of opioid-induced constipation w/ chronic non-cancer pain (including patients w/ chronic pain related to prior cancer or its treatment who do not require frequent opioid dosage escalation)? Yes☐ No☐

17. Does the member have a diagnosis of opioid-induced constipation with advanced illness or pain caused by active cancer and requires opioid dosage escalation for palliative care? Yes☐ No☐

18. Is the member's age 18 or older? Yes☐ No☐

19. Does the member have a known or suspected mechanical gastrointestinal obstruction? Yes☐ No☐

20. Has the member received opioids for at least 4 weeks duration? Yes☐ No☐

21. Has the member tried and failed Amitiza AND Movantik? Yes☐ No☐

22. Does the member have a contraindication, or intolerance to Amitiza AND Movantik? Yes☐ No☐

Please list: _____

Signature of Prescriber:_____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/