AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Relistor

Beneficiary Information

1. Beneficiary Last Name: ________________________________ 2. First Name: ________________________________
3. Beneficiary ID #: ___________________ 4. Beneficiary Date of Birth: _____________ 5. Beneficiary Gender: _________

Prescriber Information

6. Prescriber Name: _______________________________________ NPI #: ________________________
Mailing address: ______________________________________ City: _____________ State: _________ ZIP: _______
7. Requester Contact Information: ____
Name: ______________________________ Phone #: ______________________ Fax #: _______________________

Drug Information

8. Drug Name: __________________________ 9. Strength: ___________ 10. Quantity Per 30 Days: ___________
11. Length of Therapy: Initial Request: __up to 30 days __60 days __90 days __120 days
Reauthorization Request: __up to 30 days __60 days __90 days __120 days __180 days __365 days

Clinical Information

Relistor Tablets:

1. Does the beneficiary have a diagnosis of opioid-induced constipation with chronic non-cancer pain (including patients with chronic pain related to prior cancer or its treatment who do not require frequent opioid dosage escalation)? Yes___ No___
2. Is the beneficiary age 18 or older? Yes___ No___
3. Does the beneficiary have a known or suspected mechanical gastrointestinal obstruction? Yes___ No___
4. Has the beneficiary received opioids for at least 4 weeks duration? Yes___ No___
5. Has the beneficiary tried and failed Amitiza AND Movantik? Yes___ No___
6. Does the beneficiary have a contraindication, or intolerance to Amitiza AND Movantik? Yes___ No___

Please list: ____

Relistor Syringe/Vial:

7. Does the beneficiary have a diagnosis of opioid-induced constipation with chronic non-cancer pain (including patients with chronic pain related to prior cancer or its treatment who do not require frequent opioid dosage escalation)? Yes___ No___
8. Does the beneficiary 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___
9. Is the beneficiary age 18 or older? Yes___ No___
10. Does the beneficiary have a known or suspected mechanical gastrointestinal obstruction? Yes___ No___
11. Has the beneficiary received opioids for at least 4 weeks duration? Yes___ No___
12. Has the beneficiary tried and failed Amitiza AND Movantik? Yes___ No___
13. Does the beneficiary have a contraindication, or intolerance to Amitiza AND Movantik? Yes___ No___

Please list: ____

****For Re-authorizations of Relistor, please submit documentation that indicates the beneficiary has had an improvement in their symptoms from baseline.****

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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406