UnitedHealthcare Community Plan

**NC Pharmacy Prior Approval Request for**
**Selective Constipation Agents: Relistor**

## Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

## Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

## Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): Initial Authorization ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days

Re-authorization ☐ 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 w/ 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 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**
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 1-866-940-7328 Pharmacy PA Call Center: 1-855-258-1593