Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Relistor (methylnaltrexone) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Relistor (methylnaltrexone).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber a gastroenterologist, oncologist or pain specialist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Please check the boxes that apply:
□ Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

Initial Therapy:

Oral tablets

1. Member has a diagnosis of opioid induced constipation in an adult with an active opioid prescription **AND**
   □ No □ Yes
2. Opioid medication is being prescribed by an oncologist or a hospice/palliative care clinician for a member currently enrolled in hospice or palliative care program, or after consultation with a pain management specialist **AND**
   □ No □ Yes
3. Member has failed a trial of at least 2 weeks or has an intolerance or contraindication to scheduled dosing of the following medications, used in combination with other agent(s) with different mechanism of action (i.e., osmotic with a stimulant) and route of administration:
   - Polyethylene glycol
   - Lactulose or sorbitol
   - Senna
   - Bisacodyl

   □ No □ Yes

   AND
4. Inadequate response or intolerance to the following:
   - Symproic (naldemedine)
   - Movantik (naloxegol)
   - Amitiza (lubiprostone)

   □ No □ Yes

Injectable

1. Member has a diagnosis of opioid induced constipation in an adult with an active opioid prescription **AND**
   □ No □ Yes
2. Opioid medication is being prescribed by an oncologist or a hospice/palliative care clinician for a patient currently enrolled in hospice or palliative care program, or after consultation with a pain management specialist, **AND**
   □ No □ Yes
3. Member is unable to take ANY oral medications (or unable to use any oral laxatives through feeding tube) **AND**
   □ No □ Yes
4. Member has failed an adequate trial of or has an intolerance or contraindication to bisacodyl and glycerin suppositories and an enema
   □ No □ Yes

Continuation of Therapy:

1. Member has positive clinical response to Relistor (oral tablets or injectable)
   □ No □ Yes

7 – Prescriber Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**
Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility	