Prior Authorization Request Form for
Methylnaltrexone (Relistor) - tablets

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1

Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2

Please complete the clinical assessment:

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Relistor*	☐ Yes (subject to verification) Proceed to question **12**	☐ No Proceed to question **2**
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have a diagnosis of opioid-induced constipation (OIC)?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the patient concurrently taking an opioid agonist (e.g., codeine, hydrocodone, hydromorphone, morphine)?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the patient receiving other opioid antagonists (e.g., naloxone, naltrexone, nalmefene etc.)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **6**
6. Has the patient tried and failed, or is unable to tolerate at least one stimulant laxative (e.g., sennosides or bisacodyl etc.)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient tried and failed, or is unable to tolerate at least one osmotic laxaive (e.g., MiraLAX, lactulose, or magnesium citrate)?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient tried and failed therapy with naloxegol (Movantik)?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**

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9. Has the patient tried and failed therapy with naldemedine (Symproic)?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has the patient tried and failed therapy with lubiprostone (Amitiza)?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Does the patient have any of the following contraindications to the requested medication: known or suspected gastrointestinal obstruction or at an increased risk of recurrent obstruction?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
12. Is the patient continuing to take opioids?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Will the patient continue lifestyle modifications including regular use of a stimulant laxative (e.g. bisacodyl, senna), a high fiber diet, increased fluid intake, moderate exercise and opioid dose de-escalation to minimum effective dose?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Is the patient responding in a meaningful manner (e.g. improvement of at least 1 additional spontaneous bowel movement per week over baseline)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[25 July 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: