Prescriber Criteria Form

Relistor Inj 2024 PA Fax 1454-A v1 010124.docx
Relistor Injectable (methylnaltrexone bromide injectable)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Relistor Injectable (methylnaltrexone bromide injectable).

Drug Name:
Relistor Injectable (methylnaltrexone bromide injectable)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for opioid-induced constipation in a patient with advanced illness or pain caused by active cancer who requires opioid dosage escalation for palliative care? [If yes, then no further questions.]	Yes	No
2	Is the requested drug being prescribed for opioid-induced constipation in a patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation? [If no, then no further questions.]	Yes	No
3	Is the patient able to tolerate oral medications? [If no, then no further questions.]	Yes	No
4	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication that would prohibit a trial of an oral drug indicated for opioid-induced constipation in a patient with chronic non-cancer pain (e.g., Movantik)?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date:_____