WellCare
Beyond Healthcare. A Better You.

NC Medicaid and NC Health Choice
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**

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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 **1-800-678-3189** Pharmacy PA Call Center: **1-866-799-5318**