

# Relistor (Methylnaltrexone) Prior Authorization Form



**START HERE**

**Member &  
Prescriber  
Information**

Member Name:	Prescriber Name:
	Prescriber Specialty:
Member Date of Birth:	Prescriber Phone #:
Member ID #:	Prescriber Fax #:

**Criteria**

Must have opioid-induced constipation while receiving palliative care due to advanced illness.

Non-opioid causes of constipation not eligible for coverage.

Patient must have used and have documented failure to bulk laxatives, stimulant laxatives and osmotic laxatives.

Quantity limit of 14 vials (2 kits or 8.4ml) per 28 day supply for patients weighing <114 kilograms.

**Diagnosis:**

**Patient new to Relistor (methylnaltrexone) therapy**

**Therapies used for this patient's opioid-induced constipation**

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Bisacodyl    | <input type="checkbox"/> Glycolax (polyethylene glycol 3350) |
| <input type="checkbox"/> Docusate     | <input type="checkbox"/> Lactulose                           |
| <input type="checkbox"/> Ex-Lax       | <input type="checkbox"/> Miralax                             |
| <input type="checkbox"/> Other: _____ |  |

Expected duration of use: \_\_\_\_\_

**Patient continuing Relistor (methylnaltrexone) therapy**

Current Relistor Regimen: \_\_\_\_\_

Expected duration of use: \_\_\_\_\_

**Choose  
Regimen**

- Relistor** 12mg/0.6ml vial
- Relistor** 7 Tray Kit containing seven 12mg/0.6ml vials and supplies

**Provide Regimen Details:**

Patient weight (kg): \_\_\_\_\_

Patient dose: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_

**Sign/Date &  
Mail or Fax**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Prescriber NPI:** \_\_\_\_\_

**Mailing Address**

Physicians Plus Insurance Corporation  
Attn: Pharmacy Services  
P.O. Box 2078  
Madison WI 53701-2078

**Physicians Plus Pharmacy Services Fax:**

(608) 258-1905

**Prior Authorization Questions?**

(608) 260-7803 or (800) 545-5015 (ext. 7803)

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