US Family Health Plan

Prior Authorization Request Form for

Methylnaltrexone (Relistor) tablets

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Initial approval expires after 1 year, continuation approval expires after 1 year. For renewal of therapy an initial Tricare prior authorization approval is required.

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**

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8. Has the patient tried and failed therapy with naloxegol (Movantik)?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
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