OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Relistor® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Opioid-induced constipation (OIC)
- ❑ Chronic non-cancer pain
- ❑ Chronic pain related to prior cancer or its treatment
- ❑ Pain caused by active cancer (patient receiving palliative care)
- ❑ Other advanced illness (patient receiving palliative care)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Has the patient used opioid medications for a minimum of 4 weeks? ❑ **Yes** ❑ **No**
Has the patient experienced fewer than 3 bowel movements in a week? ❑ **Yes** ❑ **No**
Has the patient had bowel movements that are more than 2 days apart? ❑ **Yes** ❑ **No**
Is the patient able to swallow oral medications? ❑ **Yes** ❑ **No**
Does the patient require frequent (e.g., weekly) opioid dosage escalation? ❑ **Yes** ❑ **No**

Select the medications the patient has had a trial and failure, contraindication, or intolerance to:

❑ Lactulose
❑ Movantik
❑ Polyethylene glycol
❑ Symproic
❑ OTC laxative. Please specify drug name and date tried:_____

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is there documentation of positive clinical response to Relistor therapy (e.g., increase in bowel movements)? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading-dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

**Please note: Chart documentation (e.g., chart notes) of the above is required to be submitted with this fax form for Relistor injection requests*

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Relistor® Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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