Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Selective Constipation: Relistor

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
3. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Relistor** 2. Strength: _____ Quantity Per 30 Days: _____
1. 4. 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 member have a diagnosis of opioid-induced constipation with chronic non-cancer pain (including members w/ chronic pain related to prior cancer or its treatment who do not require frequent opioid dosage escalation)? ☐ **Yes** ☐ **No**
2. Is the member age 18 or older? ☐ **Yes** ☐ **No**
3. Does the member have a known or suspected mechanical gastrointestinal obstruction? ☐ **Yes** ☐ **No**
4. Has the member received opioids for at least 4 weeks duration? ☐ **Yes** ☐ **No**
5. Has the member tried and failed Amitiza AND Movantik? ☐ **Yes** ☐ **No**
6. Does the member have a contraindication, or intolerance to Amitiza AND Movantik? ☐ **Yes** ☐ **No**
   Please list: _____

Relistor Syringe/Vial:

7. Does the member have a diagnosis of opioid-induced constipation w/ chronic non-cancer pain (including members w/ chronic pain related to prior cancer or its treatment who do not require frequent opioid dosage escalation)? ☐ **Yes** ☐ **No**
8. Does the member 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 member age 18 or older? ☐ **Yes** ☐ **No**
10. Does the member have a known or suspected mechanical gastrointestinal obstruction? ☐ **Yes** ☐ **No**
11. Has the member received opioids for at least 4 weeks duration? ☐ **Yes** ☐ **No**
12. Has the member tried and failed Amitiza AND Movantik? ☐ **Yes** ☐ **No**
13. Does the member have a contraindication, or intolerance to Amitiza AND Movantik? ☐ **Yes** ☐ **No**
    Please list: _____

**For Re-authorizations of Relistor, please submit documentation that indicates the member 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 PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277