

**Health New England**  
**Medication Request Form (MRF)/Prescription Request**

**Relistor® (methylnaltrexone)**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

**Prior Authorization**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

**Instructions:**

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Relistor®. Please complete this form and fax to ICORE Healthcare at (800)-349-5058. If you have any questions regarding this process, please contact ICORE Healthcare at (800)-350-8119.

**Medication Request Information (please complete each section of this form prior to transmittal):**

Patient Information (all required)	Physician Information (all required)
<b>Patient Name:</b>	<b>Physician Name:</b>
<b>Patient Cell Phone #:</b> (     )     -	<b>Specialty:</b>
<b>Patient HNE ID#:</b>	<b>NPI#:</b>
<b>Patient Date of Birth:</b>	<b>HNE Provider #:</b>
<b>Allergies:</b>	<b>DEA #:</b>
<b>Diagnosis:</b>	<b>Telephone #:</b> (     )     -
	<b>Fax # (required):</b> (     )     -

**Drug Information**

<b>Requested Drug/Strength/Form:</b> <b>Relistor®</b>	HNE covers a maximum of 14 vials (2 kits or 8.4ml) per 28 day supply for patients weighing <114 kilograms; 28 vials (4 kits or 16.8ml) per 28 day supply for >114 kilograms	
<b>Dose, Directions, and length of treatment (please be specific):</b>	<b>Quantity (per month):</b>	<b>Refills:</b>

<b>Physician Signature:</b>	<b>Date:</b>
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**Indication:**

- The treatment of opioid-induced constipation in patients with advanced illnesses who are receiving palliative care, when response to laxative therapy has not been sufficient.

**Documentation of Medical Necessity (check all that apply):**

- The member has opioid-induced constipation t
- The member is receiving palliative care due to advanced illness
- The member is 18 years of age or older
- A possible mechanical gastrointestinal obstruction, known or suspected, or other non-opioid cause of constipation been ruled out
- The member has a documented failure with therapy of at least two (2) laxatives appropriate for the treatment of opioid-induced constipation within the past 6 months.
- Other pertinent history: \_\_\_\_\_