

North Carolina Department of Health and Human Services
Selective Constipation Agents PA Request Form (Relistor)

Beneficiary Information

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

Prescriber Information

6. Prescribing Provider NPI#: _____
7. Requester Contact Information Name: _____ Phone #: _____ Ext: _____

Drug Information

8. Med requested: ___ Relistor Tablet ___ Relistor Syringe/Vial
9. Quantity per 30 days _____ 9a. Duration _____

For Coverage of Relistor Tablet (For continued therapy please submit documentation that indicates the beneficiary has had an improvement in their symptoms from baseline.)

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

For Coverage of Relistor Syringe/Vial (For continued therapy please submit documentation that indicates the beneficiary has had an improvement in their symptoms from baseline.)

16. Does the beneficiary have a diagnosis of opioid-induced constipation w/ chronic non-cancer pain (including patients w/ chronic pain related to prior cancer or its treatment who do not require frequent opioid dosage escalation)? Yes ___ No ___
17. Does the beneficiary 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 ___
18. Is the beneficiary age 18 or older? Yes ___ No ___
19. Does the beneficiary have a known or suspected mechanical gastrointestinal obstruction? Yes ___ No ___
20. Has the beneficiary received opioids for at least 4 weeks duration? Yes ___ No ___
21. Has the beneficiary tried and failed Amitiza AND Movantik? Yes ___ No ___
22. Does the beneficiary have a contraindication, or intolerance to Amitiza AND Movantik? Yes ___ No ___
Please list: _____

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 NCTracks at: (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505