

03/24/2011

Prior Authorization Criteria Form

**BLUE CHIP FOR MEDICARE**

Relistor (Medicare Determination)

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to CVS|Caremark at **1-888-836-0730**.

Please contact CVS|Caremark at **1-877-203-0814** with questions regarding the prior authorization process.

When conditions are met, we will authorize the coverage of Relistor (Medicare Determination).

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**Drug Name (select from list of drugs shown)**

Relistor (methylnaltrexone bromide)

Relistor Kit (methylnaltrexone bromide)

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**Patient Information**

Patient Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Patient Group No.: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

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**Prescribing Physician**

Physician Name: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Physician Fax: \_\_\_\_\_

Physician Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

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**Diagnosis:** \_\_\_\_\_ **ICD Code:** \_\_\_\_\_

Please circle the appropriate answer for each applicable question.

1. Is the physician purchasing and providing the drug "incident to" physician services (i.e., drugs supplied and administered by a physician or under a physician's direct supervision)? Y N  
[If the answer to this question is yes, then no further questions required.]
2. Does the patient reside in one of the following long-term care (LTC) facilities? Y N
  - A nursing home that is dually-certified as both a Medicare SNF and a Medicaid nursing facility (NF)
  - A Medicaid-only NF that primarily furnishes skilled care
  - A non-participating nursing home (i.e. neither Medicare nor Medicaid) that provides primarily skilled care
  - An institution which has a distinct part SNF and which also primarily furnishes skilled care[If the answer to this question is no, then go to question 4.]
3. Is Medicare Part A paying for the LTC facility bed during the days this treatment is being requested? Y N
4. Is the request for one of the following drugs via an IV infusion pump? Y N
  - Acyclovir
  - Foscarnet

- Amphotericin B
- Fluorouracil
- Cytarabine
- Bleomycin
- Doxorubicin
- Vincristine
- Vinblastine
- Treprostinil (Remodulin)
- Cisplatin
- Gemcitabine
- Oxaliplatin
- Morphine

5. Does the member have a known or suspected mechanical gastrointestinal obstruction? Y N

[If the answer to this question is yes, then no further questions required.]

6. Does the member have a diagnosis of opioid-induced constipation with an advanced illness and is receiving palliative care? Y N

[If the answer to this question is no, then no further questions required.]

7. Has the member demonstrated an inadequate treatment response or intolerance to a drug regimen of polyethylene glycol 3350 (PEG)? Y N

[If the answer to this question is yes, then no more questions are required.]

8. Does the member have a documented contraindication to polyethylene glycol 3350 (PEG)? Y N

**Comments:** \_\_\_\_\_

I affirm that the information given on this form is true and accurate as of this date.

\_\_\_\_\_  
**Prescriber (Or Authorized) Signature and Date**