



Relistor
(Methylnaltrexone)

Express Scripts
Prior Authorization
Phone (800) 417-8164
Fax 877-837-5922

Please have the information below ready when calling in the authorization.

Member's Last Name	Member's First Name
SCAN ID number	Date of Birth
Prescriber's Name	Contact Person
Office phone	Office Fax

Medication:	Diagnosis:
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1. Is the indication for the treatment of opioid-induced constipation in patients with advanced illness who are receiving palliative care?
2. What is the member's primary diagnosis that requires a palliative opioid therapy?
3. Has the patient tried and failed therapy with one of the following formulary agents: lactulose or polyethylene glycol 3350?
4. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review?

Notice: **Failure to provide all information requested on this form may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.