



Physician's Prior Authorization Questionnaire for Relistor™

PATIENT'S NAME: _____ ID#: _____ DOB: _____

Patient Address: _____

Relistor™ is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? (no codes please) _____

2. Does the patient have a mechanical gastrointestinal obstruction? ___ Yes ___ No

3. Does the patient have terminal or end-stage disease? ___ Yes ___ No

4. Has the patient had either less than three bowel movements in the preceding week or no bowel movements for the last two days? ___ Yes ___ No

5. What other laxative therapies have failed? _____

6. Please list the opioid analgesics the patient is currently taking: _____

Relistor™ will be shipped to the patient from our Specialty Pharmacy vendor.

Physician's Signature

Date

Please **Print** Name

Fax Number

Please **Print** Physician's Specialty

Phone Number

Thank you for your assistance. Please contact Arkansas Blue Cross and Blue Shield at (501) 378-3392 if you have any questions or concerns. You also may fax your response(s) back to Arkansas Blue Cross at (501) 378-6980.

Sincerely,
Pharmacy Programs

Forms are also available online at <http://usableadmin.abcbs.net/providers/PharmacyForms.aspx>

Jan 2, 09