North Dakota Workforce Safety & Insurance

RELISTOR™ PRIOR AUTHORIZATION REQUEST

MEDICAL SERVICES DIVISION
SFN 58996 (08/2016)

1600 E Century Ave, Ste 1
PO Box 5585
Bismarck ND 58506-5585
Telephone 800-777-5033
Toll Free Fax 888-786-8695
TTY (hearing impaired) 800-366-6888
Fraud and Safety Hotline 800-243-3331
www.workforcesafety.com

SECTION 1 – *Injured worker information*

Claim number	Injured worker's (First name)	(Last name)
Date of birth		Date of request

SECTION 2 – *Provider information*

Provider's name	NPI number	Telephone number	Fax number
Address			
City		State	ZIP code

SECTION 3 – *Relistor™ prior authorization criteria*

Prior authorization criteria for Relistor™ requires documented clinical failure of at least two different classes of medications used for the treatment of constipation secondary to the opiate analgesics. Discontinuation due to patient preference or convenience does not constitute clinical failure.

Medication 1

Medication name	Strength	Dosage form
Date(s) utilized From To		
Reason medication was discontinued		

Medication 2

Medication name	Strength	Dosage form
Date(s) utilized From To		
Reason medication was discontinued		

SECTION 4 – *Signature*

I certify that Relistor™ is medically necessary for this patient's well-being. In my opinion, this is reasonable and necessary in conformance with accepted standards of medical practice for the treatment of this condition. This medication is not prescribed as a convenience to the patient or solely due to the request of the patient.

Provider's signature	**Date**

Fax this authorization form and supporting documentation to 888-786-8695

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