



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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