



Kansas Medical Assistance Program

P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

**Methylalntrexone (Relistor®)
Prior Authorization Request Form**

Beneficiary Information

Beneficiary Name: _____

Beneficiary Medicaid ID #: _____ Date of Birth: ___/___/___

Pharmacy Information

Pharmacy Name: _____

Pharmacy Medicaid ID#: _____ Pharmacy NPI#: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

Drug Name: _____ NDC Requested: _____

Prescriber Information

Prescriber's Name: _____

Prescriber's Medicaid ID#: _____ Prescriber's NPI#: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

Requested Information

1. Diagnosis for use of Relistor: _____

2. Current opioid therapy: _____

3. Documentation of inadequate response to standard laxative therapy: _____

4. Is the patient pregnant or breastfeeding?

Yes _____ No _____

5. Does the patient have a known or suspected mechanical gastrointestinal obstruction?

Yes _____ No _____

Prescriber's Signature: _____ Date: ___/___/___

**Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.**