Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP:	Office Street Address:		
Phone:			City:	State:	ZIP:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
	Directions for Use:	

Clinical Information (required)

What is the patient's diagnosis for the medication being requested?

ICD-10 Code(s): _____

What medication(s) has the patient tried and had an inadequate response to? (Please specify <u>ALL</u> medication[s]/strengths tried, length of trial and reason for discontinuation of each medication.)

What medication(s) does the patient have a contraindication or intolerance to? (Please specify <u>ALL</u> medication[s] with the associated contraindication or specific issues resulting in intolerance to each medication.)

Are there any supporting labs or test results? (Please specify.)

Quantity limit requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Patient requires a greater quantity for the treatment of a larger surface area **[topical applications only]**
- ❑ Other: _____

Information on this form is accurate as of this date.

Prescriber's Signature:	**Date:**

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: **This request may be denied unless all required information is received.**
For more information about the prior authorization process, please contact us at 855-811-2218.
Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern

OptumRx has partnered with CoverMyMeds to receive prior authorization requests,
saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.