



Prior Authorization Request Form (Page 1 of 2) COPY FOR FUTURE USE, FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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Member Information (required)			Provider Information (required)					
Member Name:			Provider Name:					
Insurance ID#:			NPI#:	t: Specialty:				
Date of Birth:			Office Phone:					
Street Address:			Office Fax:					
City:	State:	Zip:	Office Street A	Address:	:			
Phone:			City:	St	ate:		Zip:	
		Medication Inf	ormation	(required)				
Medication Name/Dos				(roquirou)				
Check if requesting	Directions for	Directions for Use:						
Check if request is for continuation of therapy								
		Clinical Info	mation (rec	quired)				
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).								
length of trial, and reason for discontinuation of each medication)								
What medication(s) does the patient have a contraindication or intolerance to? (Please specify ALL medication(s) with the								
associated contraindication to or specific issues resulting in intolerance to each medication)								
Are there any supporting labs or test results? (Please specify)								
	•							
Overstitu limit resured	-4							
Quantity limit reques What is the quantity re	equested per DAY?							
What is the reason for	or exceeding the plan							
Titration or loading						4 - 4 4 - h l -		
 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 								
 There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve 								
the same dosage a	There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosing frequency. Please specify :							
 Patient requires a g Other: 	greater quantity for the	e treatment of a larger su	urface area [Top	vical applica	ations on	ly]		
	eds the maximum EDA or	nnroved dosing of 4 grams	of acetaminophon	ner dav beer	ause he/sh	e needs evtr	- medication due to	
Note: If the patient exceeds the maximum FDA approved dosing of 4 grams of acetaminophen per day because he/she needs extra medication due to reasons such as going on a vacation, replacement for a stolen medication, provider changed to another medication that has acetaminophen, or provider								
changed the dosing of the medication that resulted in acetaminophen exceeding 4 grams per day, please have the patient's pharmacy contact the Optum Rx Pharmacy Helpdesk at (800) 788-7871 at the time they are filling the prescription for a one-time override.								
Optum Rx Pharmacy H	elpdesk at (800) 788-787	71 at the time they are fill	ing the prescripti	ion for a one	-time ove	rride.		
This document and others	if attached contain inform	nation that is privileged, co	nfidential and/or m	ay contain pr	otected he	alth informat	ion (PHI). The Provider	

named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of Optum Rx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately. Office use only: General_Quartz_2024Jan





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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 coverage determination request is not for a buy and bill drug. Optum Rx is not authorized to review requests for medications supplied by the physician's office. For additional information, please contact the patient's medical benefit.

> This request may be denied unless all required information is received. If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-496-7509. For urgent or expedited requests please call 1-800-496-7509. This form may be used for non-urgent requests and faxed to 1-844-403-1029.

Prior Authorization Department P.O. Box 2975 Mission, KS 66201 www.benefitrx.com

Optum Rx 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.

Please note: All information below is required to process this request. Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of Optum Rx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately. Office use only: General_Quartz_2024Jan