Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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/Dosage Form/Strength:

❑ Check if requesting **brand**

❑ Check if request is for **continuation of therapy**

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 ALL 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 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)

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

❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____

❑ Patient requires a greater quantity for the treatment of a larger surface area **[Topical applications only]**

❑ Other: _____

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.***

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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