OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

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## Symproic® Prior Authorization Request Form 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)			P	Provider Information (required)			
Member Name:			Provider Nam	Provider Name:			
Insurance ID#:			NPI#:		Specialty:		
Date of Birth:			Office Phone	Office Phone:			
Street Address:			Office Fax:	Office Fax:			
City:	State:	ZIP:	Office Street	Office Street Address:			
Phone:	Phone:		City:	State:	State: ZIP:		
		Medication	Information	(required)			
Medication Name:			Strength:		Dosage Fo	orm:	
			Directions for	Directions for Use:			
		Clinical In	formation (re	equired)			
Lactu	atient had a trial and f ulose ethylene glycol	or intolerance to c	one of the followin	g generics?	☐ Yes ☐ No		
<u>Information on</u>	this form is accurate	as of this date.					
Prescriber's Signature:				D	Date:		
Are there any oth this review?	ner comments, diagnose	s, symptoms, medications	tried or failed, and/or	any other information	on the physici	an feels is important to	
		led unless all required infort t the prior authorization proce		at 855-811-2218.			

Monday - Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern

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