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:		<u></u>		
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?

<u>Please note</u>: **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.

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