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

Diabetic Test Strips (all except OneTouch) 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)			Р	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:			City:	State: 2		D:	
		Medication	Information	(required)			
Medication Name:			Strength:	Dosage Form:			
			Directions for	Directions for Use:			
			nformation (re				
	requested test strips be blease submit documenta					□ Yes □ No	
Information	on this form is accurate	as of this date.					
Prescribe	er's Signature:			D	ate:		
Are there any this review?	other comments, diagnoses	s, symptoms, medications	s tried or failed, and/or	any other information	on the physician fe	eels is important to	
Please note:	This request may be denied For more information about Monday – Friday: 8 a.m. to	the prior authorization pro-	cess, please contact us a				

This document – and others if attached – contains information that is privileged, confidential and/or may contain protected health information (PHI). The provider named above is required by applicable law to safeguard PHI. The information in this document is for the sole use of OptumRx. 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: DiabeticTestStrips_2019Dec