# Please note: All information below is required to process this request Mon-Fri: 5am to10pm Pacific / Sat: 6am to 3pm Pacific

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Prior Authorization Request Form

**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: |  |  | Strength: | Dosage Form: | |
| * Check if requesting **brand** |  |  | Directions for Use: | | |
| * Check if request is for **continuation of therapy** | | |
| Is the physician supplying the medication?  **Yes**  **No** | | |
| **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 failed?**  **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: | | | | | |

**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 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 1-800-711-4555. For urgent or expedited requests please call 1-800-711-4555.

# This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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 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.**

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