Optum Rx®

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

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/Dosage Form/Strength:	
❑ Check if requesting **brand**	Directions for Use:

Clinical Information (required)

Your patient's pharmacy benefit program is administered by UnitedHealthcare, which uses Optum Rx for certain pharmacy benefit services. Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

Continuation of therapy*,¥:

Is this request for continuation of therapy? ❑ **Yes** ❑ **No**

Will medical records be submitted documenting any of the information below? ❑ **Yes** ❑ **No**

- Has the member been on the requested medication in the last 180 days or is currently stabilized? ❑ **Yes** ❑ **No**
- Has the requested medication been safe and effective in treating the member's medical condition? ❑ **Yes** ❑ **No**
- Has the member tried another prescription drug in the same pharmacological class or same mechanism of action? ❑ **Yes** ❑ **No**
- Were prior medications discontinued due to a lack of efficacy or effectiveness, diminished effect, or an adverse event? ❑ **Yes** ❑ **No**

Was the member approved for coverage of the requested medication through a prior insurance carrier? ❑ **Yes** ❑ **No**

If **yes**, please provide the end date of coverage approved by the member's prior insurance carrier:_____.

What is the member's diagnosis for the medication being requested?*

Diagnosis: _____ ICD-10 Code(s): _____

Please provide the medications the member has a failure, contraindication, or intolerance to*:

Medication: _____	Date of trial: _____	Duration of trial: _____
Medication: _____	Date of trial: _____	Duration of trial: _____
Medication: _____	Date of trial: _____	Duration of trial: _____
Medication: _____	Date of trial: _____	Duration of trial: _____
Medication: _____	Date of trial: _____	Duration of trial: _____

Prescriber attestation:

Does the prescriber attest that the information provided is true and accurate to the best of their knowledge and understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided? ❑ **Yes** ❑ **No**

Prescriber's signature: _____ Date: _____

* May not apply to all plans

¥ Please note: Chart documentation of the above is required to be submitted along with this fax form

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 within established timelines.**
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-844-403-1027.