



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

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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Cuprimine® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information <small>(required)</small>
<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Cystinuria</p> <p><input type="checkbox"/> Severe active rheumatoid arthritis</p> <p><input type="checkbox"/> Wilson’s disease (i.e., hepatolenticular degeneration)</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p>For cystinuria, answer the following:</p> <p>Has the patient had trial and failure, contraindication, or intolerance to Thiola (tiopronin)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>For severe active rheumatoid arthritis, answer the following:</p> <p>Is the patient’s condition unresponsive to conventional therapy (e.g., traditional DMARDs, TNF inhibitor, non-TF biologic)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>For Wilson’s disease (i.e., hepatolenticular degeneration), answer the following:</p> <p>Has the patient had trial and failure, contraindication, or intolerance to a penicillamine product (e.g., Depen, Cuprimine)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Reauthorization:</p> <p>Is there documentation the patient has had a positive clinical response to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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.
 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.