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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

## Egrifta<sup>®</sup> 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 <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> HIV-associated lipodystrophy					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Clinical Information:</b>					
Document the patient's waist circumference: _____ (cm/inches)					
Document the patient's hip circumference: _____ (cm/inches)					
Document the patient's waist-to-hip ratio: _____					
Is the patient's body mass index (BMI) greater than 20 kg/m <sup>2</sup> ? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the patient's fasting blood glucose (FBG) level less than or equal to 150 mg/dL (8.33 mmol/L)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient been on a stable regimen of antiretrovirals (e.g., NRTIs, NNRTI, Protease Inhibitors, Integrase Inhibitors) for at least 8 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Reauthorization:</b>					
<b>If this is a reauthorization request, answer the following question:</b>					
Is there documentation the patient has had clinical improvement (e.g., improvement in visceral adipose tissue [VAT], decrease in waist circumference, belly appearance, etc.) while on Egrifta therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Quantity Limit Requests:</b>					
What is the quantity requested per DAY? _____					
<b>What is the reason for exceeding the plan limitations?</b>					
<input type="checkbox"/> Titration or loading dose purposes					
<input type="checkbox"/> 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)					
<input type="checkbox"/> Requested strength/dose is not commercially available					
<input type="checkbox"/> 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.  
 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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