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.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Imfinzi® Prior Authorization Request Form

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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**		

Clinical Information (required)

Select the diagnosis below:

❑ Non-small cell lung cancer
❑ Urothelial carcinoma
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:
Is Imfinzi prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**

For non-small cell cancer, answer the following:
Does the patient have stage III disease? ❑ **Yes** ❑ **No**
Does the patient have unresectable disease? ❑ **Yes** ❑ **No**
Has the patient experienced disease progression following concurrent platinum-based chemotherapy and radiation therapy? ❑ **Yes** ❑ **No**
Has treatment duration with Imfinzi exceeded a total of 12 months? ❑ **Yes** ❑ **No**

For urothelial carcinoma, answer the following:
Does the patient have locally advanced or metastatic disease? ❑ **Yes** ❑ **No**
Has the patient experienced disease progression during or following platinum-containing chemotherapy? ❑ **Yes** ❑ **No**
Has the patient experienced disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy? ❑ **Yes** ❑ **No**

Reauthorization:
Does the patient show evidence of disease progression while on Imfinzi therapy? ❑ **Yes** ❑ **No**

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.

Office use only: Imfinzi_Comm_2018Jul-W