



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)			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:	
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Non-small cell lung cancer					
<input type="checkbox"/> Urothelial carcinoma					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Prescriber's Specialty:					
Is Imfinzi prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For non-small cell cancer, answer the following:					
Does the patient have stage III disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have unresectable disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient experienced disease progression following concurrent platinum-based chemotherapy and radiation therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has treatment duration with Imfinzi exceeded a total of 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For urothelial carcinoma, answer the following:					
Does the patient have locally advanced or metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient experienced disease progression during or following platinum-containing chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient experienced disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Reauthorization:					
Does the patient show evidence of disease progression while on Imfinzi therapy? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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.**
Office use only: Imfinzi_Comm_2018Jul-W