



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

Incretin Mimetics 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>					
Select the diagnosis below: <input type="checkbox"/> Type 2 diabetes mellitus <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Medication history: Select the medication(s) the patient has a trial and failure, intolerance or contraindication to: <input type="checkbox"/> Glipizide-metformin <input type="checkbox"/> Glyburide-metformin <input type="checkbox"/> Metformin <input type="checkbox"/> Metformin extended-release (ER) <input type="checkbox"/> Pioglitazone-metformin For Adlyxin requests, in addition to the above, select the medication(s) the patient has a trial and failure or intolerance to: <input type="checkbox"/> Bydureon <input type="checkbox"/> Bydureon BCise <input type="checkbox"/> Byetta <input type="checkbox"/> Ozempic <input type="checkbox"/> Trulicity <input type="checkbox"/> Victoza					
Quantity limit requests: What is the quantity requested per MONTH? _____ What is the reason for exceeding the plan limitations? <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.

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