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

Intron A® 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:

- ❑ AIDS-related Kaposi's sarcoma
- ❑ Condylomata acuminata (genital or perianal)
- ❑ Chronic hepatitis B
- ❑ Chronic hepatitis C
- ❑ Follicular non-Hodgkin lymphoma (Stage III or IV)
- ❑ Hairy cell leukemia
- ❑ Malignant melanoma
- ❑ Metastatic renal cell carcinoma
- ❑ Multiple myeloma (maintenance therapy)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

For chronic hepatitis B, answer the following:
Does the patient have decompensated liver disease (defined as Child-Pugh Class B or C)? ❑ **Yes** ❑ **No**

For chronic hepatitis C, answer the following:
Does the patient have decompensated liver disease (defined as Child-Pugh Class B or C)? ❑ **Yes** ❑ **No**
Has the patient previously been treated with interferon? ❑ **Yes** ❑ **No**
Will Intron A be used in combination with ribavirin? ❑ **Yes** ❑ **No**
If "no" to the above question, does the patient have contraindication or intolerance to ribavirin? ❑ **Yes** ❑ **No**

For metastatic renal cell carcinoma, answer the following:
Will Intron A be used in combination with Avastin (bevacizumab)? ❑ **Yes** ❑ **No**
Is Intron A prescribed by or in consultation with an oncologist? ❑ **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.

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