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

Portrazza® 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:
❑ Squamous non-small cell lung cancer
❑ Other diagnosis: _____   ICD-10 Code(s): _____

Clinical Information:
Does the patient have metastatic disease? ❑ **Yes** ❑ **No**
Will the patient use Portrazza in combination with gemcitabine? ❑ **Yes** ❑ **No**
Will the patient use Portrazza in combination with cisplatin? ❑ **Yes** ❑ **No**
Will Portrazza be used as first-line treatment? ❑ **Yes** ❑ **No**
Is Portrazza prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**

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

Quantity Limit Requests:
What is the quantity requested per 21 days? _____
What is the reason for exceeding the plan limitations?
❑ Titration or loading dose purposes
❑ 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)
❑ Requested strength/dose is not commercially available
❑ 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.