



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

Qutenza® 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> |
|--|
| <p>Select the diagnosis below:</p> <p><input type="checkbox"/> Neuropathic pain associated with postherpetic neuralgia</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p> |
| <p>Medication history:</p> <p>Does the patient have a history of failure or intolerance to over-the-counter capsaicin? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have a history of failure, contraindication, or intolerance to topical lidocaine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>Reauthorization:</p> <p>Has it been at least 3 months since the last Qutenza application/administration? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient experienced pain relief with a prior course of Qutenza? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient experiencing a return of neuropathic pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>Quantity limit requests:</p> <p>What is the quantity requested per MONTH? _____</p> <p>What is the reason for exceeding the plan limitations?</p> <p><input type="checkbox"/> Titration or loading dose purposes</p> <p><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)</p> <p><input type="checkbox"/> Requested strength/dose is not commercially available</p> <p><input type="checkbox"/> Other: _____</p> |

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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Office use only: Qutenza_Comm_2019Jan1-W