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

Short-Acting Opioids 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:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Cancer
❑ Postoperative pain
❑ Other diagnosis: ___________________________ ICD-10 Code(s): ___________________________

End of life care:

Is the patient receiving opioids as part of end of life care? ❑ **Yes** ❑ **No**

Postoperative pain:

Is the requested medication being prescribed for pain related to a dental procedure? ❑ **Yes** ❑ **No**
Is the requested dose prescribed the same dose that the patient was stable on prior to discharge? ❑ **Yes** ❑ **No**

Other diagnoses:

Does the prescriber certify that there is an active treatment plan that includes but is not limited to a specific treatment objective and the use of other pharmacological and non-pharmacological agents for pain relief as appropriate? ❑ **Yes** ❑ **No**

Does the prescriber certify that there has been an informed consent document signed and an addiction risk assessment has been performed? ❑ **Yes** ❑ **No**
If **No**, has the prescriber (or prescriber's representative) verbally addressed the above with the patient? ❑ **Yes** ❑ **No**

Does the prescriber certify that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists? ❑ **Yes** ❑ **No**
If **No**, has the prescriber (or prescriber's representative) verbally addressed the above with the patient? ❑ **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?

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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: Short-ActingOpioids_Comm_2018Sep-W