



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit [go.covermymeds.com/OptumRx](http://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

## Symproic<sup>®</sup> 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:
<input type="checkbox"/> Check if requesting <b>brand</b>	Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>		

Clinical Information (required)
<p><b>Select the diagnosis below:</b></p> <p><input type="checkbox"/> Opioid-induced constipation (OIC) in patients with chronic non-cancer pain</p> <p><input type="checkbox"/> Opioid-induced constipation (OIC) in patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>

<p><b>Select the medications the patient has had a trial and failure, contraindication, or intolerance to:</b></p> <p><input type="checkbox"/> Lactulose</p> <p><input type="checkbox"/> Polyethylene glycol</p>
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<p><b>Reauthorization request:</b></p> <p><b>For reauthorization requests, answer the following:</b></p> <p>Is there documentation of positive clinical response to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p><b>Quantity limit requests:</b></p> <p>What is the quantity requested per DAY? _____</p> <p><b>What is the reason for exceeding the plan limitations?</b></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>
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<p><b>Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?</b></p> <p>_____</p> <p>_____</p>
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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.

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