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

Temodar® (temozolomide) 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:

❑ Newly diagnosed glioblastoma multiforme
❑ Refractory anaplastic astrocytoma
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:
Is Temodar (temozolomide) prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**

For newly diagnosed glioblastoma multiforme, answer the following:
Is the patient's condition newly diagnosed? ❑ **Yes** ❑ **No**
Is the patient using Temodar (temozolomide) concomitantly with radiotherapy? ❑ **Yes** ❑ **No**
Will Temodar (temozolomide) be used as maintenance treatment? ❑ **Yes** ❑ **No**

For refractory anaplastic astrocytoma, answer the following:
Has the patient's condition progressed on a drug regimen containing a nitrosourea agent and procarbazine? ❑ **Yes** ❑ **No**

Reauthorization:
If this is a reauthorization request, answer the following question:
Does the patient show evidence of progressive disease while on Temodar (temozolomide) therapy? ❑ **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.