



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

Zortress® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)	Provider Information (required)
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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 brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)

Select the diagnosis below:

Prophylaxis of organ rejection in kidney transplantation

Prophylaxis of organ rejection in liver transplantation

Other diagnosis: _____ ICD-10 Code(s): _____

Provider's Specialty:
Is the prescriber experienced in immunosuppressive therapy and management of transplant patients? Yes No

For prophylaxis of organ rejection in kidney transplantation, answer the following:
Is the medication being used for prevention of kidney transplant organ rejection? Yes No
Is the patient at low-to-moderate immunologic risk? Yes No
Select if the patient is prescribed concurrent therapy with reduced doses of the following:
 Cyclosporine
 Corticosteroids

For prophylaxis of organ rejection in liver transplantation, answer the following:
Is the medication being used for prevention of liver transplant organ rejection? Yes No
Have thirty (30) or more days passed since the transplant procedure? Yes No
Select if the patient is prescribed concurrent therapy with reduced doses of the following:
 Tacrolimus
 Corticosteroids

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.