



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

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:		
Clinical Information <small>(required)</small>					
Your patient's pharmacy benefit program is administered by UnitedHealthcare, which uses OptumRx for certain pharmacy benefit services. Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.					
Continuation of therapy**:					
Is this request for continuation of therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Will medical records be submitted documenting any of the information below? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the member been on the requested medication in the last 180 days or is currently stabilized? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the requested medication been safe and effective in treating the member's medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the member tried another prescription drug in the same pharmacological class or same mechanism of action? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Were prior medications discontinued due to a lack of efficacy or effectiveness, diminished effect, or an adverse event? <input type="checkbox"/> Yes <input type="checkbox"/> No					
What is the member's diagnosis for the medication being requested?*					
Diagnosis: _____			ICD-10 Code(s): _____		
Please provide the medications the member has a failure, contraindication, or intolerance to*:					
Medication: _____		Date of trial: _____		Duration of trial: _____	
Medication: _____		Date of trial: _____		Duration of trial: _____	
Medication: _____		Date of trial: _____		Duration of trial: _____	
Medication: _____		Date of trial: _____		Duration of trial: _____	
Medication: _____		Date of trial: _____		Duration of trial: _____	
Prescriber attestation:					
Does the prescriber attest that the information provided is true and accurate to the best of their knowledge and understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Prescriber's signature: _____			Date: _____		

* May not apply to all plans

** Please note: Chart documentation of the above is required to be submitted along with this fax form

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 within established timelines.

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.**

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