



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

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

Clinical Information <small>(required)</small>
<p><b>***Please note: A review of the vial will be conducted unless otherwise indicated.***</b></p> <p><b>Select the diagnosis below:</b></p> <p><input type="checkbox"/> Type 1 diabetes mellitus</p> <p><input type="checkbox"/> Type 2 diabetes mellitus</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p><b>Select the medications the patient has a failure, contraindication, or intolerance to:</b></p> <p><input type="checkbox"/> Humalog cartridge</p> <p><input type="checkbox"/> Humalog Junior KwikPen</p> <p><input type="checkbox"/> Humalog KwikPen</p> <p><input type="checkbox"/> Humalog vial</p> <p><input type="checkbox"/> Novolog Flexpen</p> <p><input type="checkbox"/> Novolog Penfill</p> <p><input type="checkbox"/> Novolog vial</p>
<p><b>For Admelog vials, also answer the following (does <u>NOT</u> apply to Admelog SoloStar):</b></p> <p>Is Admelog administered using an infusion pump? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was the infusion pump paid for by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Select <u>ONE</u> of the following:</b></p> <p><input type="checkbox"/> Admelog is administered at home (not including facility providing skilled nursing care)</p> <p><input type="checkbox"/> The patient is in a long-term care (LTC) facility (e.g., hospital or skilled nursing facility where patient is receiving skilled care)</p>

**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.  
 If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.  
 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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