



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

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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Alprazolam Intensol, alprazolam orally disintegrating tablet (ODT), Xanax® (alprazolam), Xanax XR® (alprazolam extended-release [ER]) 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:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information <small>(required)</small>															
Select the diagnosis below: <input type="checkbox"/> Anxiety [Alprazolam Intensol, alprazolam ODT, Xanax (alprazolam) only] <input type="checkbox"/> Panic disorder, with or without agoraphobia <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____															
Select the medications the patient has a failure, contraindication, or intolerance to: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Alprazolam</td> <td><input type="checkbox"/> Clonazepam immediate-release (IR) tablet</td> <td><input type="checkbox"/> Klonopin</td> </tr> <tr> <td><input type="checkbox"/> Alprazolam ER</td> <td><input type="checkbox"/> Clonazepam ODT</td> <td><input type="checkbox"/> Lorazepam</td> </tr> <tr> <td><input type="checkbox"/> Alprazolam Intensol</td> <td><input type="checkbox"/> Clorazepate</td> <td><input type="checkbox"/> Oxazepam</td> </tr> <tr> <td><input type="checkbox"/> Alprazolam ODT</td> <td><input type="checkbox"/> Diazepam</td> <td><input type="checkbox"/> Tranxene T</td> </tr> <tr> <td><input type="checkbox"/> Chlordiazepoxide</td> <td><input type="checkbox"/> Diazepam Intensol</td> <td></td> </tr> </table>	<input type="checkbox"/> Alprazolam	<input type="checkbox"/> Clonazepam immediate-release (IR) tablet	<input type="checkbox"/> Klonopin	<input type="checkbox"/> Alprazolam ER	<input type="checkbox"/> Clonazepam ODT	<input type="checkbox"/> Lorazepam	<input type="checkbox"/> Alprazolam Intensol	<input type="checkbox"/> Clorazepate	<input type="checkbox"/> Oxazepam	<input type="checkbox"/> Alprazolam ODT	<input type="checkbox"/> Diazepam	<input type="checkbox"/> Tranxene T	<input type="checkbox"/> Chlordiazepoxide	<input type="checkbox"/> Diazepam Intensol	
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<input type="checkbox"/> Chlordiazepoxide	<input type="checkbox"/> Diazepam Intensol														
Clinical information: Is the requested drug being used concomitantly with ketoconazole? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the requested drug being used concomitantly with itraconazole? <input type="checkbox"/> Yes <input type="checkbox"/> No															
Quantity limit requests: What is the quantity requested per DAY? _____ What is the reason for exceeding the plan limitations? <input type="checkbox"/> Titration or loading-dose purposes <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) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. Please specify: _____ <input type="checkbox"/> Other: _____															

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.

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