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

Apidra SoloStar® & Apidra® Vial
Prior Authorization Request Form (Page 1 of 2)

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

Member Information (required)			Provider Information (required)		
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:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

*****Please note: A review of the vial will be conducted unless otherwise indicated. *****

Select the diagnosis below:
❑ Type 1 diabetes mellitus
❑ Type 2 diabetes mellitus
❑ Other diagnosis: ________________________________ ICD-10 Code(s): ____

For Apidra SoloStar, select the medications the patient has a failure, contraindication, or intolerance to:
❑ Fiasp FlexTouch
❑ Humalog cartridge
❑ Humalog Junior KwikPen
❑ Humalog KwikPen
❑ Novolog Flexpen
❑ Novolog Penfill

For Apidra vial, select the medications the patient has a failure, contraindication, or intolerance to:
❑ Fiasp vial
❑ Humalog vial
❑ Novolog vial

For Apidra vials, also answer the following (does NOT apply to Apidra SoloStar):

Is Apidra administered using an infusion pump? ❑ **Yes** ❑ **No**

Was the infusion pump paid for by Medicare? ❑ **Yes** ❑ **No**

Is the patient using a subcutaneous insulin pump [excluding disposable drug delivery systems (e.g., OmniPod, V-Go)]? ❑ **Yes** ❑ **No**

Is the patient enrolled in a comprehensive diabetes program with one of the following symptoms? ❑ **Yes** ❑ **No**

- Dawn phenomenon
- Fluctuations in blood glucose
- Hemoglobin level (HbA1C) greater than 7 percent
- History of recurring hypoglycemia
- History of severe glycemic excursions

Has the patient been on an external insulin infusion pump prior to enrollment in Medicare and has documented frequency of glucose self-testing an average of at least 4 times per day? ❑ **Yes** ❑ **No**

Does the patient have a fasting blood sugar less than or equal to 225mg/dL? ❑ **Yes** ❑ **No**

Does the patient have a Beta cell autoantibody test that is positive? ❑ **Yes** ❑ **No**

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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.**

Apidra SoloStar® & Apidra® Vial
Prior Authorization Request Form (Page 2 of 2)

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Select ONE of the following:

- ☐ Apidra is administered at home (not including facility providing skilled nursing care)
- ☐ The patient is in a long-term care (LTC) facility (e.g., hospital or skilled nursing facility where patient is receiving skilled care)

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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