**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

# Egrifta® Prior Authorization Request Form

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

## Member Information (required)

| | | |
|---|---|---|
| Member Name: | | |
| Insurance ID#: | | |
| Date of Birth: | | |
| Street Address: | | |
| City: | State: | Zip: |
| Phone: | | |

## Provider Information (required)

| | | |
|---|---|---|
| Provider Name: | | |
| NPI#: | Specialty: | |
| Office Phone: | | |
| Office Fax: | | |
| Office Street Address: | | |
| 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)

**Select the diagnosis below:**

❑ HIV-associated lipodystrophy

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

**Clinical Information:**

Does the patient have a waist circumference of greater than or equal to 95 cm (37.4 inches) in men or 94cm (37 inches) in women? ❑ **Yes** ❑ **No**

Does the patient have a waist-to-hip ratio of greater than or equal to 0.94 for men or 0.88 for women? ❑ **Yes** ❑ **No**

Does the patient have a body mass index (BMI) of greater than 20 $kg/m^2$? ❑ **Yes** ❑ **No**

Does the patient have fasting blood glucose (FBG) levels less than or equal to 150 mg/dL (8.33 mmol/L)? ❑ **Yes** ❑ **No**

Has the patient been on a stable regimen of antiretrovirals (e.g., NRTIs, NNRTI, Protease Inhibitors, Integrase Inhibitors) for at least 8 weeks? ❑ **Yes** ❑ **No**

**Reauthorization:**

**If this is a reauthorization request, answer the following question:**

Is there documentation the patient has had clinical improvement [e.g., improvement in visceral adipose tissue (VAT), decrease in waist circumference, belly appearance, etc.] while on Egrifta therapy? ❑ **Yes** ❑ **No**

**Quantity Limit:**

What is the quantity requested per MONTH? _____

**What is the reason for exceeding the plan limitations?**

❑ Titration or loading-dose purposes

❑ 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)

❑ Requested strength/dose is not commercially available

❑ 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**: _____

❑ 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.