



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

Epinephrine Products 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:

- Emergency treatment of allergic reactions (Type 1), including anaphylaxis
- Other diagnosis: _____ ICD-10 Code(s): _____

Select the medications the patient has a failure, contraindication, or intolerance to:

- Epinephrine (generic AdrenaClick)
- Epinephrine (generic EpiPen)
- Epinephrine (generic EpiPen Jr.)
- EpiPen 2-Pak
- EpiPen Jr. 2-Pak

Quantity limit requests:

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.