



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

Firmagon[®] 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"/> Advanced prostate cancer | |
| <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____ | |
| Clinical Information: | |
| Does the patient have advanced or metastatic prostate cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Is Firmagon prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Is this request for continuation of prior Firmagon therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Has the patient been on Firmagon within the past 120 days? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Quantity limit requests: | |
| What is the quantity requested per MONTH? _____ | |
| 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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