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

Guanfacine 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** ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:
❑ Hypertension
❑ Other diagnosis: ______________________________ ICD-10 Code(s): ____________________________________

The approval criteria is based on the guidance provided by the Centers for Medicare & Medicaid Services (CMS), the Pharmacy Quality Alliance, the American Geriatric Society and the National Committee for Quality Assurance (NCQA). "Use of High Risk Medications in the Elderly" is measure 238 of the Centers for Medicare & Medicaid Services Physician Quality Reporting System.

Risk acknowledgment:

Does the provider acknowledge that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population? ❑ **Yes** ❑ **No**

Does the provider wish to proceed with the originally prescribed medication? ❑ **Yes** ❑ **No**

Coverage of the drug is approvable after demonstrated failure to the alternatives below or we receive information as to why they would be inappropriate.

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

❑ Accupril
❑ Acebutolol
❑ Adalat CC
❑ Aldactone
❑ Altace
❑ Amlodipine
❑ Atacand
❑ Atenolol
❑ Avapro
❑ Benazepril
❑ Benicar
❑ Betaxolol
❑ Bisoprolol
❑ Bystolic
❑ Candesartan
❑ Captopril
❑ Carospir
❑ Carvedilol
❑ Carvedilol phosphate extended-release (ER)
❑ Chlorthalidone
❑ Coreg
❑ Coreg CR
❑ Cozaar
❑ Diovan
❑ Edarbi
❑ Enalapril
❑ Eprosartan
❑ Felodipine ER
❑ Fosinopril
❑ Irbesartan
❑ Kapspargo Sprinkle
❑ Lisinopril
❑ Lopressor
❑ Losartan
❑ Lotensin
❑ Metoprolol succinate ER
❑ Metoprolol tartrate
❑ Micardis
❑ Moexipril
❑ Nifedipine ER
❑ Nisoldipine ER
❑ Norvasc
❑ Olmesartan
❑ Perindopril
❑ Prinivil
❑ Procardia XL
❑ Qbrelis
❑ Quinapril
❑ Ramipril
❑ Spironolactone
❑ Sular
❑ Telmisartan
❑ Tenormin
❑ Toprol XL
❑ Trandolapril
❑ Valsartan
❑ Vasotec
❑ Zestril

❑ Other angiotensin-converting enzyme (ACE) inhibitor, angiotensin II receptor blocker (ARB), beta-blocker or combination product based on specific chronic conditions. Please specify: ____
❑ Other second generation calcium channel blocker (CCB). Please specify:______________________________________
❑ Other thiazide (taken at a low dose). Please specify:____

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.**

Guanfacine Prior Authorization Request Form (Page 2 of 2)

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Quantity limit requests:

What is the quantity requested per DAY? ______

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.

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