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

Intron A® Prior Authorization Request Form

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:

❑ AIDS-related Kaposi's sarcoma
❑ Chronic hepatitis B
❑ Chronic hepatitis C
❑ Condylomata acuminata (genital or perianal)
❑ Follicular non-Hodgkin's lymphoma (stage III or IV)
❑ Hairy cell leukemia
❑ Malignant melonoma
❑ Metastatic renal cell carcinoma (RCC)
❑ Multiple myeloma (maintenance therapy)
❑ Other diagnosis: ___________________________________ ICD-10 Code(s): _______________________________

For all diagnoses, answer the following:
Is this request for continuation of prior Intron A therapy? ❑ **Yes** ❑ **No**
Has the patient been on Intron A within the past 120 days? ❑ **Yes** ❑ **No**

For chronic hepatitis B, also answer the following:
Does the patient have decompensated liver disease? ❑ **Yes** ❑ **No**

For chronic hepatitis C, also answer the following:
Does the patient have decompensated liver disease? ❑ **Yes** ❑ **No**
Has the patient previously been treated with interferon? ❑ **Yes** ❑ **No**
Will Intron-A be used in combination with ribavirin? ❑ **Yes** ❑ **No**
Does the patient have **contraindication or intolerance** to ribavirin? ❑ **Yes** ❑ **No**

For metastatic renal cell carcinoma (RCC), also answer the following:
Will Intron A be used in combination with Avastin (bevacizumab)? ❑ **Yes** ❑ **No**
Is Intron A prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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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.

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.**
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