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

Lynparza® 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)

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:

- ❑ Breast cancer
- ❑ Ovarian cancer
  - ❑ Epithelial ovarian cancer
  - ❑ Fallopian tube cancer
  - ❑ Primary peritoneal cancer
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is Lynparza prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**
Is this request for continuation of prior Lynparza therapy? ❑ **Yes** ❑ **No**
Has the patient been on Lynparza within the past 120 days? ❑ **Yes** ❑ **No**
Is there presence of deleterious or suspected deleterious germline BRCA-mutations as detected by an FDA-approved test or at a Clinical Laboratory Improvement Amendments-approved facility? ❑ **Yes** ❑ **No**

For breast cancer, answer the following:

Does the patient have metastatic disease? ❑ **Yes** ❑ **No**
Does the patient have recurrent disease? ❑ **Yes** ❑ **No**
Does the patient have human epidermal growth factor receptor 2 (HER2)-negative disease? ❑ **Yes** ❑ **No**
Has the patient been previously treated with chemotherapy (e.g., anthracycline, taxane) in the neoadjuvant, adjuvant, or metastatic setting? ❑ **Yes** ❑ **No**
Does the patient have hormone receptor (HR)-positive disease? ❑ **Yes** ❑ **No**
Has the patient experienced disease progression on prior endocrine therapy? ❑ **Yes** ❑ **No**
Is there provider attestation that endocrine therapy is inappropriate for the patient's disease? ❑ **Yes** ❑ **No**

For ovarian cancer, answer the following:

Select if the patient has the following disease characteristics:

- ❑ Advanced
- ❑ Persistent
- ❑ Recurrent

Does the patient have trial and failure, contraindication, or intolerance to three or more prior lines of chemotherapy (e.g., paclitaxel with cisplatin)? ❑ **Yes** ❑ **No**
Is Lynparza used for maintenance treatment in patients who have had complete or partial response to platinum-based chemotherapy (e.g., cisplatin, carboplatin)? ❑ **Yes** ❑ **No**

Lynparza® Prior Authorization Request Form (Page 2 of 2)

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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.