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

Novolin® Products 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:
❑ Type 1 diabetes mellitus
❑ Type 2 diabetes mellitus
❑ Other diagnosis: _____ ICD-10 Code(s): _____

The following are the formulary alternatives:
For Novolin N vial & Novolin N Relion vial**- Humulin N vial**
For Novolin R vial & Novolin R Relion vial**- Humulin R vial**
For Novolin 70/30 vial & Novolin 70/30 Relion vial**- Humulin 70/30 vial**
For Novolin 70/30 FlexPen & Novolin 70/30 FlexPen Relion - **Humulin 70/30 KwikPen**
Will the patient be switched to one of the following formulary alternatives? ❑ **Yes** ❑ **No**
If **yes**, please specify which alternative the patient will be switched to and notify the pharmacy of the change: _____
If the patient CANNOT be switched to a formulary alternative, please answer ALL of the following questions:

1) What previous medication(s) has the patient tried or failed for the diagnosis provided:
_____
2) If the patient has failed, had adverse reactions, or contraindications to the above formulary alternative(s), provide clinical details as to what occurred:
_____
_____

Please note: Submit chart documentation/medical records to support the information you have provided above

For Novolin R or Novolin R Relion requests, answer the following (does NOT apply to Novolin N, Novolin N Relion, Novolin 70/30, Novolin 70/30 Relion, Novolin 70/30 FlexPen, or Novolin 70/30 FlexPen Relion):
Is Novolin R or Novolin R Relion administered using an infusion pump? ❑ **Yes** ❑ **No**
Was the infusion pump paid for by Medicare? ❑ **Yes** ❑ **No**
Is the patient using a subcutaneous insulin pump [excluding disposable drug delivery systems (e.g., OmniPod, V-Go)]? ❑ **Yes** ❑ **No**
Is the patient enrolled in a comprehensive diabetes program with one of the following symptoms? ❑ **Yes** ❑ **No**

- Dawn phenomenon
- Fluctuations in blood glucose
- Hemoglobin level (HbA1C) greater than 7 percent
- History of recurring hypoglycemia
- History of severe glycemic excursions

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Has the patient been on an external insulin infusion pump prior to enrollment in Medicare and has documented frequency of glucose self-testing an average of at least 4 times per day? ❑ **Yes** ❑ **No**

Does the patient have a fasting blood sugar less than or equal to 225mg/dL? ❑ **Yes** ❑ **No**

Does the patient have a Beta cell autoantibody test that is positive? ❑ **Yes** ❑ **No**

Select ONE of the following:

❑ Novolin R or Novolin R Relion is administered at home (not including facility providing skilled nursing care)

❑ The patient is in a long-term care (LTC) facility (e.g., hospital or skilled nursing facility where patient is receiving skilled care)

Prescriber attestation:

Does the prescriber attest that the information provided on this form is true and accurate? ❑ **Yes** ❑ **No**

Prescriber signature: _____ Date: _____

(Please note: if a non-formulary exception is approved, the requested drug will process at the **highest** brand tier copay for the plan year)

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.