



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

Ozempic® 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:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Type 2 Diabetes Mellitus	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Select the medications the patient has a failure, contraindication, or intolerance to:	
<input type="checkbox"/> Adlyxin	
<input type="checkbox"/> Adlyxin Starter Pack	
<input type="checkbox"/> Bydureon Bcise	
<input type="checkbox"/> Bydureon Pen	
<input type="checkbox"/> Bydureon vial	
<input type="checkbox"/> Byetta	
<input type="checkbox"/> Glucophage	
<input type="checkbox"/> Glucophage XR	
<input type="checkbox"/> Metformin	
<input type="checkbox"/> Metformin ER (generic Fortamet)	
<input type="checkbox"/> Metformin ER (generic Glucophage XR)	
<input type="checkbox"/> Metformin ER (generic Glumetza)	
<input type="checkbox"/> Riomet	
<input type="checkbox"/> Trulicity	
<input type="checkbox"/> Victoza	
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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