



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations. Visit [go.covermymeds.com/OptumRx](http://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

## Symproic<sup>®</sup> 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 <b>brand</b>	Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>		

Clinical Information (required)	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Opioid-induced constipation (OIC)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
<b>Clinical information:</b>	
Does the patient have chronic non-cancer pain? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient have chronic pain related to prior cancer or its treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there documentation of opioid use for at least 4 weeks prior to the proposed start of therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Select the medications the patient has a failure, contraindication, or intolerance to:</b>	
<input type="checkbox"/> Amitiza	
<input type="checkbox"/> Constulose	
<input type="checkbox"/> Enulose	
<input type="checkbox"/> Generlac	
<input type="checkbox"/> Kristalose	
<input type="checkbox"/> Lactulose	
<input type="checkbox"/> Other osmotic laxative (e.g., MiraLax/PEG 3350 polyethylene glycol [PEG])	
<b>Quantity limit requests:</b>	
What is the quantity requested per DAY? _____	
<b>What is the reason for exceeding the plan limitations?</b>	
<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. <b>Please specify:</b> _____	
<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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