



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

Tekturna® & Tekturna HCT® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>	Provider Information <small>(required)</small>
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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 <small>(required)</small>
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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 <small>(required)</small>
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Select the diagnosis below:

Hypertension

Other diagnosis: _____ ICD-10 Code(s): _____

Select the medications the patient has a failure, contraindication, or intolerance to:

<input type="checkbox"/> Amlodipine-olmesartan	<input type="checkbox"/> Losartan
<input type="checkbox"/> Amlodipine-valsartan	<input type="checkbox"/> Losartan-HCTZ
<input type="checkbox"/> Amlodipine-valsartan-hydrochlorothiazide (HCTZ)	<input type="checkbox"/> Olmesartan
<input type="checkbox"/> Candesartan	<input type="checkbox"/> Olmesartan-amlodipine-HCTZ
<input type="checkbox"/> Candesartan-HCTZ	<input type="checkbox"/> Olmesartan-HCTZ
<input type="checkbox"/> Edarbi	<input type="checkbox"/> Telmisartan
<input type="checkbox"/> Edarbyclor	<input type="checkbox"/> Telmisartan-amlodipine
<input type="checkbox"/> Eprosartan	<input type="checkbox"/> Telmisartan-HCTZ
<input type="checkbox"/> Irbesartan	<input type="checkbox"/> Valsartan
<input type="checkbox"/> Irbesartan-HCTZ	<input type="checkbox"/> Valsartan-HCTZ

Generic angiotensin converting enzyme (ACE) inhibitor (e.g., benazepril, captopril, enalapril, fosinopril, lisinopril, moexipril, perindopril, quinapril, ramipril, trandolapril)

Generic ACE inhibitor combination (e.g., amlodipine-benazepril, benazepril-HCTZ, captopril-HCTZ, enalapril-HCTZ, fosinopril-HCTZ, lisinopril-HCTZ, moexipril-HCTZ, quinapril-HCTZ, trandolapril-verapamil extended-release [ER])

Quantity limit requests:
What is the quantity requested per DAY? _____

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.

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