# Zostavax® Prior Authorization Request Form

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

<table>
<thead>
<tr>
<th>Member Information (required)</th>
<th>Provider Information (required)</th>
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<tbody>
<tr>
<td><strong>Member Name:</strong></td>
<td><strong>Provider Name:</strong></td>
</tr>
<tr>
<td><strong>Insurance ID#:</strong></td>
<td><strong>NPI#:</strong></td>
</tr>
<tr>
<td><strong>Date of Birth:</strong></td>
<td><strong>Office Phone:</strong></td>
</tr>
<tr>
<td><strong>Street Address:</strong></td>
<td><strong>Office Fax:</strong></td>
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<tr>
<td><strong>City:</strong></td>
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<td><strong>Zip:</strong></td>
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</tbody>
</table>

**Medication Information (required)**

- **Medication Name:**
- **Strength:**
- **Dosage Form:**
- **Directions for Use:**
- Check if requesting **brand**
- Check if request is for **continuation of therapy**

**Clinical Information (required)**

- **Select the diagnosis below:**
  - Prevention of herpes zoster (shingles)
  - Other diagnosis: ___________________________  ICD-10 Code(s): ___________________________

- **Clinical Information:**
  - Is Zostavax being used for the prevention of herpes zoster (shingles)?  □ Yes  □ No
  - Has the patient had a trial and failure, contraindication, or intolerance to Shingrix (zoster vaccine recombinant, adjuvanted)?  □ Yes  □ No
  - Has the patient had a previous Zostavax injection?  □ Yes  □ No
    - If "yes" to the above question, please document the date of injection: ____________________ (mm/dd/yyyy)

- 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.

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