Please note: All information below is required to process this request
Mon-Fri: 5am to10pm Pacific / Sat: 6am to 3pm Pacific
For real time submission 24/7 visit www.OptumRx.com and click Health Care Professionals
OptumRx • M/S CA 106-0286 • 3515 Harbor Blvd. • Costa Mesa, CA 92626

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:
☐ Check if requesting **brand**	Is the physician supplying the medication? ☐ **Yes** ☐ **No**	
Directions for Use:	**Continuation of therapy?** ☐ **Yes** ☐ **No** If "**YES**", answer the following: Has member been on this medication in the last 180 days?* ☐ **Yes** ☐ **No** Does the prescriber confirm that the medication has been effective in treating the member's medical condition?* ☐ **Yes** ☐ **No**	

Clinical Information (required)

Your patient's pharmacy benefit program is administered by UnitedHealthcare, which uses OptumRx for certain pharmacy benefit services. Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

What is the patient's diagnosis for the medication being requested?

_____

Please provide the medications the member has a failure, contraindication, or intolerance to:

Medication: _____ Date: _____

Medication: _____ Date: _____

Medication: _____ Date: _____

Medication: _____ Date: _____

Prescriber attestation:

Does the prescriber attest that the information provided is true and accurate to the best of their knowledge and understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided? ☐ **Yes** ☐ **No**

Prescriber's signature: _____ Date: _____

***** May not apply to all plans

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 within established timelines.**
This request may be denied unless all required information is received.
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.