Prior Authorization Request Form
Fax Back To: 1-800-853-3844
Phone: 1-800-711-4555
5 AM – 7 PM PST M-F

Prior Authorization Form

Patient Information

Patient's Name:

Insurance ID: Date of Birth: Height: Weight:

Address: Apartment #:

City: State: Zip:

Phone Number: Alternate Phone: Sex: ☐ Male ☐ Female

Provider Information

Provider's Name: Provider ID Number:

Address: City: State: Zip:

Suite Number: Building Number:

Phone Number: Fax number:

Provider's Specialty:

Medication Information

Medication: Quantity: ICD9 Code:

Directions: Diagnosis: Refills:

Will the physician supply this medication? ☐Yes ☐No

By providing the information it will only be used for coverage determination request administered by OptumRx.

Medication Instructions

Has the patient been instructed on how to **Self-Administer**? ☐Yes ☐No

Is this medication a **New Start**? ☐Yes ☐No

If **NO** please provide the following: Initiation Date: / / Date of Last Dose: / /

This is to notify you that your patient's request for this medication may be denied unless we receive supportive information, i.e., medications tried and failed, document improvement with medication(s). Please provide information to support this request. Please fax back at the number listed above or call at 1-800-711-4555.

Administration Instructions

Dispensing Location: Physician's Office ☐ Patient's Address ☐ Date medication is needed: / /

Medication Administered: Home Health ☐ Self Administered ☐ LTC ☐ Physician's Office ☐

*If you have any questions regarding your patient's plan drug limits you may call us at: 1-800-711-4555.

OptumRx Specialty Prior Authorization (continued)

Document the patient's diagnosis: _____ ICD-9 Code: _____

Please Document all that applies to the Patient

Has the patient been evaluated for tuberculosis and treated accordingly? ☐Yes ☐No

Document date of last PPD test: _____ ☐Negative ☐Positive

For Diagnosis of **Rheumatoid Arthritis or Ulcerative Colitis**: Does the Patient exhibit symptoms of MODERATE to SEVERE?
☐Yes ☐No

For Diagnosis of **Psoriasis**: Does the patient have failure, intolerance or contraindication to: (**Please circle all that apply**)
Ultraviolet Light B (UVB), Pulsed Dye Laser, Photochemotherapy, Psoralen and exposure to Ultraviolet light a (PUVA)

For Diagnosis of **Crohn's Disease**: Does the patient exhibit symptoms of MODERATE to SEVERE? ☐Yes ☐No
Has induction dose been prescribed? ☐Yes ☐No (if **NO** document reason why it has not been prescribed)

Document if the patient has tried, failed or had contraindication

- ☐ Methotrexate
- ☐ Imuran (azathioprine)
- ☐ Cyclosporine (Sandimmune, Neoral)
- ☐ Gold compounds (Myochrisine, Ridura, Aurolate, and Solganal)
- ☐ Plaquenil (hydroxychloroquine)
- ☐ Arava (leflonomide)
- ☐ Cuprimine (penicillamine)
- ☐ Aminosalicylates (e.g. sulfasalazine, azulfidine, mesalamine)
- ☐ 6-mercaptopurine (Purnethol)
- ☐ NSAIDs (e.g. Ibuprofen)
- ☐ 6-thioguanine
- ☐ Acitretin (soriatane)
- ☐ Hydroxyurea (hydrea)
- ☐ Mycophenolate (cellcept)
- ☐ Corticosteroids

Please Document Dates of therapies for medications selected: _____
Please document any clinical contraindications to these medications: _____

Has the patient had a trial, failure or contraindication to any of the following medications? (Please list dosage and/or contraindication)

			Dosage / Contraindication
Enbrel®	☐Yes	☐No	_____
Humira®	☐Yes	☐No	_____
Remicaid®	☐Yes	☐No	_____
Orencia®	☐Yes	☐No	_____
Kineret®	☐Yes	☐No	_____
Simponi®	☐Yes	☐No	_____
Cimzia®	☐Yes	☐No	_____
Actemra®	☐Yes	☐No	_____
Stelara®	☐Yes	☐No	_____

Continuation of Therapy

Has the patient utilized the medication in the past 45 days? ☐Yes ☐No
Has the patient had documented clinical improvement from ongoing therapy? ☐Yes ☐No
(Please document dose reduction or reason for high dose [if applicable])

***If the above information is not available, please attach the patient's chart notes documenting clinical improvement.**

*If you have any questions regarding your patient's plan drug limits you may call us at: 1-800-711-4555.

For UHC members: Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage can be provided. Please complete the following questions 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 plan's rules