OPTUMRx®

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
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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: Rollo, Ian			Provider Name: Mantis Tobaggan, DDS		
Insurance ID#: MX3335555			NPI#: N43567	Specialty: Dentistry	
Date of Birth: March 15, 1997			Office Phone: 888-888-8888		
Street Address: 4151 Willamette Ave			Office Fax: 999-999-9999		
City: San Diego	State: CA	Zip: 92117	Office Street Address: 555 Legume Drive		
Phone: 6087204376			City: Jamaica	State: CA	Zip: 87596

Medication Information (required)

Medication Name: Amoxycillin	Strength: 500 MG	Dosage Form: Lozenge
☐ Check if requesting **brand**	Directions for Use: Take orally morning and night.	
☐ Check if request is for **continuation of therapy**		
Is the physician supplying the medication? ☐ **Yes** ☐ **No**		

Clinical Information (required)

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

Big boo-boo ICD-10 Code(s): I:10 - Big boo-boo, unknown cause.

What medication(s) has the patient tried and failed?

200mg hugs and kisses
1g comforting words

Are there any supporting labs or test results? (Please specify)

Mom looked at it and said "yeesh"

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**: _____
- ☐ Patient requires a greater quantity for the treatment of a larger surface area **[Topical applications only]**
- ☐ 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.