OPTUMRx®

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

Prior Authorization Request Form (Page 1 of 2)

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

Member Information (required)

Member Name: **Aiden Smith**			
Insurance ID#: **7891023**			
Date of Birth: **08-10-2004**			
Street Address: **18 N Ontario St**			
City: **New York**	State: **NY**	Zip: **21022**	
Phone: **555-876-3416**			

Provider Information (required)

Provider Name: **Dr. Lisa Lauren**		
NPI#: **1234876**	Specialty: **Pediatric Oncology**	
Office Phone: **555-426-7898**		
Office Fax: **555-426-7899**		
Office Street Address: **1423 Miracle Drive**		
City: **New York**	State: **NY**	Zip: **21023**

Medication Information (required)

Medication Name: **Everolimus**	Strength: **5mg/m2 once daily**	Dosage Form: **oral tablet**
❑ Check if requesting **brand**	Directions for Use: **Take 5mg/m2 once daily in conjunction with 200 mg/m² of Nexavar twice daily.**	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Proactive Benefit Review:
❑ Check if this is a proactive request for a 2020 benefit determination

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

ICD-10 Code(s): **C40.0**

What medication(s) has the patient tried and had an inadequate response to? (Please specify ALL medication(s)/strengths tried, length of trial, and reason for discontinuation of each medication)

Neoadjuvant Therapy: March 10, 2024 – April 21, 2024
Doxorubicin, Cisplatin, Methotrexate (3 cycles). Surgery: May 1, 2024 - Limb-sparing surgery.
Adjuvant Therapy: May 22, 2024 – September 4, 2024 Doxorubicin, Cisplatin, Methotrexate, Ifosfamide (6 cycles).

What medication(s) does the patient have a contraindication or intolerance to? (Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)

N/A

Are there any supporting labs or test results? (Please specify) **MRI left femur and CT chest that indicate recurrence of tumor in distal left femur and new mets to lung (see attached documentation)**

Use of High Risk Medications (HRMs) in the elderly (applies on patients ≥ 65 years ONLY):
"Use of High Risk Medications in the Elderly" is measure 238 of the Centers for Medicare & Medicaid Services Physician Quality Reporting System.

Does the provider acknowledge that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population? ❑ **Yes** ❑ **No**
Does the provider wish to proceed with the originally prescribed medication? ❑ **Yes** ❑ **No**

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Prior Authorization Request Form (Page 2 of 2)

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Quantity limit requests:
What is the quantity requested per DAY? **5mg/m2 based on BSA**

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: _____

Note: *If the patient exceeds the maximum FDA approved dosing of 4 grams of acetaminophen per day because he/she needs extra medication due to reasons such as going on a vacation, replacement for a stolen medication, provider changed to another medication that has acetaminophen, or provider changed the dosing of the medication that resulted in acetaminophen exceeding 4 grams per day,* ***please have the patient's pharmacy contact the OptumRx Pharmacy Helpdesk at (800) 788-7871 at the time they are filling the prescription for a one-time override.***

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Pleases see attached physician clinic note regarding medical necessity as well as supporting labs, imaging, and pathology reports

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 1-844-403-1028.