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

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

Member Information (required)

Member Name: Maxie Millionaire		
Insurance ID#: 7656432		
Date of Birth: 06-15-22		
Street Address: 14126 Garnett St		
City: Boston	State: MA	Zip: 02108
Phone: 555-987-2254		

Provider Information (required)

Provider Name: Dr. Lennox		
NPI#: 1234567	Specialty: Pediatrics	
Office Phone: 555-345-7865		
Office Fax: 555-345-7866		
Office Street Address: 84 North Avenue		
City: Boston	State: MA	Zip: 02108

Medication Information (required)

Medication Name: Epidiolex	Strength: 100 mg/mL	Dosage Form: Liquid
❑ Check if requesting **brand**	Directions for Use: Take 2.5mg/kg/day divided in two doses for one week, then increase to 5mg/kg/day divided in two doses.	

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.

Continuation of therapy*,¥:

Is this request for continuation of therapy? ❑ **Yes** ☑ **No**

Will medical records be submitted documenting any of the information below? ☑ **Yes** ❑ **No**

- Has the member been on the requested medication in the last 180 days or is currently stabilized? ❑ **Yes** ☑ **No**
- Has the requested medication been safe and effective in treating the member's medical condition? ❑ **Yes** ❑ **No**
- Has the member tried another prescription drug in the same pharmacological class or same mechanism of action? ❑ **Yes** ☑ **No**
- Were prior medications discontinued due to a lack of efficacy or effectiveness, diminished effect, or an adverse event? ☑ **Yes** ❑ **No**

What is the member's diagnosis for the medication being requested?*

Diagnosis: Lennox-Gustaut Syndrome ICD-10 Code(s): _____

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

Medication:	Valproic acid	Date of trial:	May 1-June 1, 2024	Duration of trial:	4 weeks
Medication:	Lamotrigine	Date of trial:	May 14, 2024 - current	Duration of trial:	Current therapy
Medication:	Rufinamide	Date of trial:	June 1-August 1, 2024	Duration of trial:	8 weeks
Medication:	Topiramate	Date of trial:	August 1, 2024 - current	Duration of trial:	Current therapy
Medication:		Date of trial:		Duration of trial:	

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: Lennox Date: 10-23-24

* May not apply to all plans

¥ Please note: Chart documentation of the above is required to be submitted along with this fax form

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 see supporting documents including medical notes, imaging and laboratory results

Please note: **This request may be denied unless all required information is received within established timelines.**
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-844-403-1027.