PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name: Optum Rx

Plan/Medical Group Phone#: (800) 711-4555

Plan/Medical Group Fax#: (844) 403-1027

Non-Urgent ___ **Exigent Circumstances ___**

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request. **Information contained in this form is Protected Health Information under HIPAA.**

Patient Information

First Name: _____ Last Name: _____ MI: ____ Phone Number: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Date of Birth:____Male _ Female _ HT:___ WT:___ Allergies: __

Patient's Authorized Representative (if applicable): _____

Authorized Representative Phone Number: _____

Insurance Information

Primary Insurance Name:_____Patient ID Number: _____

Secondary Insurance Name:_____Patient ID Number: _____

Prescriber Information

First Name:_____Last Name:_____Specialty:_____

Address:_____City:_____State:___ Zip Code: _____

Requester (if different than prescriber): _____

Office Contact Person:_____NPI Number (individual): _____

Phone Number:_____DEA Number (is required): _____

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Fax Number (in HIPPA complaint area):_____Email: _____

Medication / Medical and Dispensing Information

Medication Name: _____

New Therapy: ___ Renewal: ___ Step Therapy Exception Request: ___

If Renewal: Date Therapy Initiated: _____

Duration of Therapy (specific dates): _____

How did the patient receive the medication?

Paid under Insurance Name: _____

Prior Authorization Number (if known):_____Other (explain): _____

Dose/Strength:_____Frequency:_____Length of Therapy/#Refills: _____

Quantity:_____Therapy/# Refills: _____

Administration:

Oral/SL:___Topical:__ Injection:____IV:___Other: _____

Administration Location:

Physician's Office: ___ Ambulatory Infusion Center:____ Patient's Home: ___

Home Care Agency: ___ Outpatient Hospital Care: ___ Long Term Care: ___

Other (explain): _____

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Patient Name:_____ID# _____

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step therapy exception request.

1. **Has the patient tried any other medication for this condition?**

   Yes (if yes, complete below):____ No: ___

Medications/Therapy (specify Drug Name and Dosage): _____

_____

Duration of Therapy (Specify Dates): _____

Response/Reason for Failure/Allergy: _____

2. **List Diagnoses:**

   _____

   ICD-10:

   _____

3. Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

   Attachments ___

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Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____

Date: _____

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

Plan/Insurer Use Only: Date/Time Request Received by

Plan/Insurer:_____ Date/Time of Decision _____

Fax Number: _____

Approved:____ Denied:___ Comments/Information Requested: _____
