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: _____

Does the patient have a Relapsing form of Multiple Sclerosis (MS)? ☐ Yes ☐ No

Document which applies to the patient:

- ☐ Relapsing-Remitting Multiple Sclerosis (RRMS)
- ☐ Progressive-Relapsing Multiple Sclerosis (PRMS)
- ☐ Secondary-Progressive Multiple Sclerosis
- ☐ Recent history of first clinical demyelinating event (e.g., Optic Neuritis, Incomplete Transverse Myelitis or Brainstem/ Cerebellar Syndrome)

If the patient has a recent history of first clinical demyelinating event, does the patient have MRI-detected brain lesions consistent with Multiple Sclerosis? ☐ Yes ☐ No

Does the patient have a history of failure, intolerance, or contraindication to any of the following medications?

Avonex	☐ Yes	☐ No
Betaseron	☐ Yes	☐ No
Copaxone	☐ Yes	☐ No
Rebif	☐ Yes	☐ No
Extavia	☐ Yes	☐ No
Gilenya	☐ Yes	☐ No

Initial Ampyra Therapy:

Is there Physician confirmation that the patient has difficulty walking? ☐ Yes ☐ No

Reauthorization for Ampyra Therapy:

Is there Physician confirmation that the patient has improved walking with Ampyra? ☐ Yes ☐ No

***If the above information is not available, attach the patient's chart notes applicable to the diagnosis (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.