



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Clorazepate 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:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)

Continuation of therapy:
 Is this a continuation of prior therapy? Yes No
 If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: **(REQUIRED)**

Select the diagnosis below:

Alcohol withdrawal syndrome
 Anxiety
 Partial seizures (adjunct therapy)
 Other diagnosis: _____ ICD-10 Code(s): _____

Medication history:
 Has the patient had prior use of ONE of the following alternatives or are the listed alternatives contraindicated, inappropriate, or ineffective for this patient: clonazepam, diazepam, or lorazepam? Yes No

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
 Other: _____

For continuation of existing therapy, also answer the following:

Would sudden discontinuation of the dose trigger withdrawal symptoms? Yes No
 Would discontinuation of the dose be unsafe for the patient and their condition may worsen or exacerbate? Yes No
 Is the prescribing provider attempting to taper or reduce the dose necessary? Yes No

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.
 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.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
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