



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

Visit [go.covermymeds.com/OptumRx](http://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

## Clorazepate Prior Authorization Request Form

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

### Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

### Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

### Medication Information (required)

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

### 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)**

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**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?**

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**Please note:** This request may be denied unless all required information is received.  
 For urgent or expedited requests please call 1-855-297-2870.  
 This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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