



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

Insulin Pens Prior Authorization Request Form

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

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>			
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 <small>(required)</small>
<p>Continuation of therapy: Is this a continuation of prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> 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)</p> <hr/>

<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Type 1 diabetes mellitus</p> <p><input type="checkbox"/> Type 2 diabetes mellitus</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
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<p>Clinical information: Is the patient unable to draw up insulin into a syringe to self-administer due to mechanical, physical, or environmental issues? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have visual impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have a severe phobia to traditional syringes and needles that is documented by chart notes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are there contraindications or absolute drug interactions with existing therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>For Lantus SoloStar requests, also answer the following:</p> <p>Is the patient currently using Lantus? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient new to Lantus therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have a prior history of Basaglar? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>For Apidra Pen requests, also answer the following:</p> <p>Does the patient have a history of failure, contraindication, or intolerance to Humalog? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?</p> <hr/>

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.

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