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

Miacalcin® Injection 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:
❑ Check if requesting **brand**	Directions for Use:	
❑ 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:

- ❑ Hypercalcemia
- ❑ Paget's disease of bone
- ❑ Postmenopausal osteoporosis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is there presence of contraindications or absolute drug interactions with existing therapy? ❑ **Yes** ❑ **No**

Select if there are chart notes or documentation of any of the following:

- ❑ BMD T-score: _____
- ❑ 10 year fracture risk of hip (greater than or equal to 3 %) or major-osteoporosis related fracture (greater than or equal to 20 %)

Will the prescriber provide a statement or chart notes showing the patient has had failure, contraindication, or intolerance to one of the following: risedronate, alendronate, or ibandronate? ❑ **Yes** ❑ **No**

Will the prescriber provide a statement or chart notes showing the patient has had an intolerance or contraindication to calcitonin nasal spray? ❑ **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.**