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

Mirvaso® 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 Information	Provider Information
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:
❑ Persistent (nontransient) erythema of rosacea
❑ Other diagnosis: _____   ICD-10 Code(s): _____

Clinical information:

Does the patient have a prior trial and failure of **BOTH** metronidazole and finacea? ❑ **Yes** ❑ **No**

Are there contraindications or absolute drug interactions with existing therapy? ❑ **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 1-855-297-2870.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.