



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

Moxifloxacin tablet 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/> <hr/> |

| |
|---|
| <p>Select the diagnosis below:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Acute bacterial exacerbation of chronic bronchitis <input type="checkbox"/> Acute bacterial sinusitis <input type="checkbox"/> Community acquired pneumonia <input type="checkbox"/> Complicated intra-abdominal infections <input type="checkbox"/> Complicated skin and skin structure infections <input type="checkbox"/> Plague <input type="checkbox"/> Uncomplicated skin and skin structure infections <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____ |
|---|

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|--|
| <p>Clinical information: Are there contraindications or absolute drug interactions with existing therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</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?

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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