



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

## Vancocin® (vancomycin) 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:
<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)
<p><b>Continuation of therapy:</b>            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: <b>(REQUIRED)</b></p> <p>_____</p> <p>_____</p>
<p><b>Select the diagnosis below:</b></p> <p><input type="checkbox"/> Clostridium difficile-associated diarrhea</p> <p><input type="checkbox"/> Enterocolitis due to Staphylococcus aureus</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p><b>Clinical information:</b>            Are there contraindications or absolute drug interactions with existing therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>For Clostridium difficile-associated diarrhea, also answer the following:</b>            Select the severity of the patient's Clostridium difficile-associated diarrhea:</p> <p><input type="checkbox"/> Mild-moderate</p> <p><input type="checkbox"/> Severe</p> <p>Has the patient had a trial of metronidazole? <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?

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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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