Optum Rx®

Prescription Drug Reference Pricing Program
Lower Copay / Cost Share Reduction Prior Authorization Form

Fax To: 866-511-2202

Mail To: Prior Authorization Department
P.O. Box 3214, Lisle, Illinois 60532-8214
Phone: 800-626-0072

Patient Information:

Name:_____ Date of Birth:_____ Member ID:_____

Pharmacy Information:

Name:_____ Phone:_____ Fax:_____

Medication Information:

Name and Strength of Drug:_____ Quantity & Dosing:_____

Diagnosis: _____ Duration of Therapy:_____

Prescriber MUST submit a statement of clinical justification indicating any ONE of the following below Please select all that apply and provide statement of clinical justification
☐ **Low Cost Alternative Drug is <u>contraindicated</u> due to any of the following:** • Adverse outcome, Drug interaction, Toxicity, or Allergy
☐ **Low Cost Alternative Drug has been <u>previously tried with therapeutic failure</u>**
☐ **Patient is <u>stable on current drug</u>(s) AND has <u>high risk of significant adverse clinical outcome</u> with medication change** • Provide information indicating this is a continuation of therapy request (e.g., length of therapy, start date, etc.) **AND** • Provide clinical justification indicating high risk of destabilization, significant adverse clinical outcomes are likely if discontinued
☐ **Low Cost Alternative Drug <u>would be less effective</u> in this patient** • Drug itself is less effective in this patient, or • Patient would be less compliant on the Low-Cost Alternative Drug

☐ **Prescriber documents "DAW-1" AND provides supporting clinical information**
• Must state, Dispense as Written 1= Substitution Not Allowed by Prescriber
  ○ Only Daw-1 is considered
  ○ All other DAW Codes are not accepted (e.g., DAW 0, 2-9)
AND
• Provide clinical justification that meets any ONE of the clinical criteria outlined above

☐ ****REQUIRED** Statement of clinical justification: (Information to be considered and used in determination of this exception.)** _____ _____

Prescriber Information:

Name:_____ Specialty:_____

DEA/NPI: _____ Phone: _____ : _____

I attest that the information given on this form is *accurate* as *of this date.*

Prescriber or Authorized Signature

_____ Date: _____

I understand that use or disclosure of individually identifiable health Information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996.