Optum Rx®

For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-844-403-1027.

Healthcare Reform Copay Waiver 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)

Your patient's pharmacy benefit program is administered by UnitedHealthcare, which uses Optum Rx for certain pharmacy benefit services. Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

What is the patient's diagnosis for the medication being requested?

ICD-10 Code(s): _____

For contraceptives, ONLY the following section needs to be answered:

Is the patient using the prescribed drug for contraception? ❑ **Yes** ❑ **No**

Is the requested product medically necessary? ❑ **Yes** ❑ **No**

For all other products, please answer the following:

What medication(s) has the patient tried and had an inadequate response to? (Please specify ALL medication(s)/strengths tried, length of trial, and reason for discontinuation of each medication)

For all other products, please answer the following:

What medication(s) does the patient have a contraindication or intolerance to? (Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)

For all other products, please answer the following:

Are there any supporting labs or test results? (Please specify)

For all other products, please answer the following:

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Patient requires a greater quantity for the treatment of a larger surface area **[Topical applications only]**
- ❑ Other: _____

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.
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