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

Imiquimod Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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:

❑ Actinic keratosis
❑ External genital warts
❑ Superficial basal cell carcinoma
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Are there contraindications or absolute drug interactions with existing therapy? ❑ **Yes** ❑ **No**

Will the requested medication be used for more than 120 treatment days per year? ❑ **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.