



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

Xhance® Prior Authorization Request Form

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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> <p>_____</p> <p>_____</p>
<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Nasal polyps</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p>Clinical Information:</p> <p>Does the patient have chronic rhinosinusitis (CRS) with nasal polyps? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is there clinical documentation of visualization of nasal polyps? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient had an appropriate trial (30 day of therapy) of one inhaled nasal corticosteroid? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">If "yes" to the above question, please specify: _____</p> <p>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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