Optum Rx®

Member Pays the Difference (MPD) Exceptions
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:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Diagnosis:

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

ICD-10 Code(s): _____

Answer the following:

Has the patient tried and failed the generic? ❑ **Yes** ❑ **No**

Does the patient have a documented allergy to the generic? ❑ **Yes** ❑ **No**

Does the patient have other clinical reasons (e.g., drug interactions, safety concerns) requiring the brand? ❑ **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 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.