TOPICAL AGENT PRIOR AUTHORIZATION REQUEST FORM

OptumRx
P.O. Box 25184
Santa Ana, CA, 92799
Phone: (800) 310-6826 Fax: (866) 940-7328

Today's Date
☐☐ / ☐☐☐ / ☐☐☐☐

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retro-active PA ☐	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication	Strength	Quantity	Dosage Regimen	Diagnosis

PA Requirements:

1. What is the prescriber's specialty? _____
2. Have any other providers been consulted in the prescribing of the requested agent? ☐ Yes ☐ No
   If yes, please provide the other provider's specialty: _____
3. Has the member tried and failed any other medication(s) for the requested diagnosis? ☐ Yes ☐ No
   If yes, please provide drug/dose/date(s) of use:

Drug(s) and Dose	Dates of Use

4. Provide medical justification for use at requested dose and duration:

Additional Drug-Specific Questions: **(Not required if not applicable)**

Topical NSAIDs:

1. Are oral medications unsuitable for member use? ☐ Yes ☐ No
   If yes, faxed prescriber documentation (e.g., medical chart record) is required to be attached.

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