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 1-844-403-1029.

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)

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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Office use only: HCR_Comm_2023Sep