Optum Rx®

Member Pays the Difference (MPD) Exceptions
Prior Authorization Request Form

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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?

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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.

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