********IHS AND 638 TRIBAL FACILITY / PHARMACY*********

AUTHORIZATION FORM FOR SUBMISSION TO OPTUMRX

Medication Request Form

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Prescriber:
Pharmacy:
Patient:

OPTUMRX Prior Authorization Department
P.O. Box 5252
Lisle, Il 60532-5252
Fax: 866-463-4838

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #

Instructions:

This Medication Request Form is only for use by prescribing clinicians for AHCCCS FFS members and must be signed by the prescribing clinician. In addition to member identifying data, the prescribing clinician must provide the medication requested, the dosage and the clinical justification/rationale for the request. If the request is for a drug not listed on the AHCCCS Drug List, the documentation must demonstrate why the member cannot use the medication(s) listed on the drug list. The Medication Request Form is also used to request overrides for step therapy, quantity limits and other edits. If you have any questions regarding this process, please contact Optum Rx's Customer Service at (855) 577-6310. **Please complete this form and fax to Optum Rx at (866) 463-4838.**

Pharmacy Instructions for After Hours Emergencies, Hospital Discharges & Care Transitions

The participating network pharmacy staffs are to contact the Optum Rx's Customer Service Unit at (855) 577-6310 to request medication overrides for after-hours emergencies, hospital discharges or patients transitioning from the hospital to a lower level of care; this also includes antibiotic infusion requests.

☐ **CHECK HERE IF THE PATIENT IS A DIRECT TRANSFER FROM A HOSPITAL TO A LONG-TERM CARE FACILITY.**

Medication Request Information (please complete each section of this form prior to submission): *Denotes Required Fields

PATIENT INFORMATION		**PRESCRIBING CLINICIAN INFORMATION**	
*Name:		*Name:	
*ID#:		*Specialty:	
*Date of Birth:		ID# / DEA#:	
*Health Plan:		*Phone: ( ) -	*Fax: ( ) -
*Diagnosis (ICD-9 Code, if known):			
REQUESTED DRUG INFORMATION		**PHARMACY INFORMATION**	
*Requested Drug:		Name:	
Dose:	Strength:	Phone: ( ) -	Fax: ( ) -
Quantity: (per month)	Dosage Form: (Oral, Injection, etc.)	Length of Treatment: (Please be specific.)	
Clinical Justification for the Requested Medication:			
Other Medications Tried and/or Failed (Please be specific, give detail.):			
Additional Information / Other Pertinent History:			
*Prescriber Signature Required:		Date:	