



Please note: All information below is required to process this request.  
 Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern



## Topical Corticosteroids Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NP#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<b>What is the patient's diagnosis for the medication being requested?</b> _____ ICD-10 Code(s): _____					
<b>Select if the patient has a trial and failure to any of the following generic topical medications:</b>					
<input type="checkbox"/> Alclometasone dipropionate		<input type="checkbox"/> Fluocinolone			
<input type="checkbox"/> Amcinonide		<input type="checkbox"/> Fluocinonide			
<input type="checkbox"/> Augmented betamethasone		<input type="checkbox"/> Fluticasone			
<input type="checkbox"/> Betamethasone dipropionate		<input type="checkbox"/> Halobetasol			
<input type="checkbox"/> Betamethasone valerate		<input type="checkbox"/> HC butyrate			
<input type="checkbox"/> Clobetasol		<input type="checkbox"/> HC valerate			
<input type="checkbox"/> Clocortolone pivalate		<input type="checkbox"/> Hydrocortisone 2.5%			
<input type="checkbox"/> Desonide		<input type="checkbox"/> Mometasone			
<input type="checkbox"/> Desoximetasone		<input type="checkbox"/> Prednicarbate			
<input type="checkbox"/> Diflorasone		<input type="checkbox"/> Triamcinolone			
<b>**Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.**</b> <b>*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*</b>					
Prescriber Signature: _____			Date: _____		

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 1-800-527-0531.

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