Prior Authorization Form
General/Non-Preferred Drugs

TN Division of TennCare

Optum Rx®

Access this PA form at: https://www.optumrx.com/oe_tenncare/landing

Drug & drug class-specific PA forms must be used whenever available. Specific PA forms linked below.

For most up-to date list, please visit the website above.

Acute Opioid	Cystic Fibrosis	GLP-1 Agonists	Mavyret	Proton Pump Inhibitors	TZD & Combos
Antidepressant-SNRI	Chronic Opioid	Growth Hormone	Narcolepsy	Promethazine (Age < 2 years old)	Vosevi
Anti-Anxiety	Compounds	Harvoni	Ophthalmic NSAID	Schedule II Stimulants	Zepatier
Atypical Antipsychotic	Diabetic Supply	High Potency Statin	Opioid Exceptions	Sovaldi	
Beta-Agonist Combos	DPP-4 Inhibitors	I/DD	OTC Agents	Synagis	
Buprenorphine Products	Epclusa	Influenza Antiviral	PCSK9 Inhibitors	Topical Immunomodulator	

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member, per drug, please.

Member Information (REQUIRED)			Prescriber Information (REQUIRED)	
Member Name:			Provider Name:	
OptumRx ID #:			NPI #:	DEA #:
Date of Birth:				Specialty:
Street Address:			Office Phone:	Office Fax:
City:	State:	Zip:	Supervising Physician and DEA # (if applicable):	
Phone:			Office Street Address:	
			City:	State: / Zip:
			Is the prescriber a single-patient contract holder for this patient? ☐ Yes ☐ No	
			Is the prescriber a TennCare provider with a Medicaid ID? ☐ Yes ☐ No	

Requested PA Required Drug

Drug: _____ Dosage form: _____Strength: _____

Directions: _____ Qty: _____Duration of therapy requested: _____

Compounded product: ☐ Yes ☐ No If available, can the generic equivalent be used? ☐ Yes ☐ No

Clinical Criteria Documentation

1. What is the diagnosis for this this drug is requested? _____

2. Has the patient failed an adequate trial of a preferred drug? ☐ Yes ☐ No
   If the answer is yes, please list each drug tried and result:

Drug	Strength	Length of Trial	Reason for Discontinuation

3. Has the patient experienced an adverse event or had an intolerance to a preferred drug? ☐ Yes ☐ No
   If the answer is yes, please list each drug tried and result:

Drug	Strength	Describe adverse event or intolerance

4. Is the patient currently taking the requested drug? ☐ Yes ☐ No
   If yes, how has the medication been supplied? _____

5. Please include any other information pertinent to the PA Request: _____
   _____
   _____

Prescriber Signature (Required)	Date
By signature, the prescriber confirms the above information is accurate and verifiable by patient records.	

Fax this form to 1-866-434-5523

Phone: 1-866-434-5524

OptumRx will provide a response within 24 hours upon receipt.