Optum

Prior Authorization Release Form

The Authorized signature field can be filled out with a digital signature (download PDF to sign) or handwritten (print PDF to sign). All other fields must be filled out electronically (typed).

Practice name: _____

Practice address: _____
Street City State Zip

Phone: _____

I authorize Optum Pharmacy 702, LLC and its affiliated specialty pharmacies and representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient(s), and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data required to support a prior authorization request. In all cases where the prior authorization request requires prescriber signature, Optum Specialty Pharmacy will clearly note that it is the pharmacy submitting the request on my behalf and may attach this form as evidence of such prescriber signature.

In the event Optum Specialty Pharmacy determines that it is unable to fulfill a prescription, I understand Optum Specialty Pharmacy will no longer pursue the prior authorization for such prescription and I further authorize Optum Specialty Pharmacy to forward such prescription and any materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

This authorization is effective as of the date signed and remains in effect until revoked by me. I understand that I may revoke this authorization at any time by completing and submitting the revocation anytime by faxing or emailing this completed form with the revocation box checked below at **855-640-7016** or OptumPAForm@optum.com

Prescriber first & last name:	NPI:
Prescriber first & last name:	NPI:
Prescriber first & last name:	NPI:
Prescriber first & last name:	NPI:
Prescriber first & last name:	NPI:
Prescriber first & last name:	NPI:
Prescriber first & last name:	NPI:
Prescriber first & last name:	NPI:
Prescriber first & last name:	NPI:
Prescriber first & last name:	NPI:

Signature (Authorized Practice Individual)**:** _____

Printed name: _____ **Date**: _____

Title: _____ **Phone:** _____

Email: _____

Please revoke this form immediately by checking this box: ☐

Submission of this form does not guarantee Prior Authorization will be submitted on your behalf

Please complete this form and fax or email to **855-640-7016** or OptumPAForm@optum.com

If you need more space, use a separate sheet(s).