

Please note: All information below is required to process this request.

Fax to 1-844-403-1029 Mon-Sat: 7am to 7pm Central

Oravig® Prior Authorization Request Form
DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)				
Member Name:			Provider Name:				
Insurance ID#:			NPI#:	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 Fo	orm:	
☐ Check if requesting brand			Directions for Use:				
☐ Check if request is for continuation of therapy							
Clinical Information (required)							
Select the diagnosis below:							
□ Local treatment of oropharyngeal candidiasis (OPC)							
☐ Other diagnosis:			ICD-10 Code(s):				
Clinical information:							
Has the patient had a trial and failure of clotrimazole troches, fluconazole tablets/suspension, or nystatin							
suspension within the past 60 days? Yes No							
Quantity limit requests:							
What is the quantity requested per DAY? What is the reason for exceeding the plan limitations?							
☐ Titration or loading dose purposes							
☐ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two							
tablets at bedtime)							
□ Requested strength/dose is not commercially available□ Other:							
U Other:							
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 1-855-401-4262.						

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.

This form may be used for non-urgent requests and faxed to 1-844-403-1029.