

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

Fax to 1-844-403-1029

Mon-Sat: 7am to 7pm Central

## Tirosint®capsule/levothyroxine capsule 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#: Specialty:			
Date of Birth:			Office Phone:			
Street Address:			Office Fax:			
City:	State:	Zip:	Office Street Address:			
Phone:			City: State: Zip:		Zip:	
Medication Information (required)						
Medication Name:			Strength: Dosage Form		orm:	
☐ Check if requesting <b>brand</b>			Directions for Use:			
☐ Check if request is for continuation of therapy						
Clinical Information (required)						
Enter diagnosis below:						
Diagnosis: ICD-10 Code(s):						
New to Tirosint capsule or levothyroxine capsule therapy:  Has the patient tried 2 different levothyroxine tablets in the last 180 days? □ Yes □ No						
Has the patient experienced failure to levothyorixine tablets?  Yes  No If yes, explain						
Submit documentation of medication failure.						
Does the patient have an allergy, contraindication, drug-to-drug interaction, or history of unacceptablet/toxic side effects with levothyroxine tablets?   Yes  No If yes, explain						
TOTOTITY TOTALIS CADIOCO. WE TOO WE TOO IT YOU, OAPIGIT						
Submit documentation of allergy, contraindication, drug-to-drug interaction, or history of unacceptable/toxic side effects with levothyroxine tablets.						
Patient is currently taking Tirosint capsule/levothyroxine capsule therapy:						
Has the patient tried 2 different levothyroxine tablets?   Yes No If yes, explain  Submit documentation of trial and failure.						
Quantity limit requests:						
What is the quantity requested per MONTH?						
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?						
Diagon notes	request may be desired and	oo oll required information	io received			
For u	rgent or expedited request	ess all required information is please call 1-855-401-426 urgent requests and faxed t	52.			

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.

Office use only: Tirosint SouthDakotaMedicaid 2023July