

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

Fax to 1-844-403-1029

Mon-Sat: 7am to 7pm Central

Zorbtive® 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:	Provider Name:		
Insurance ID#:			NPI#:		Specialty:	
Date of Birth:			Office Phone:	Office Phone:		
Street Address:			Office Fax:	Office Fax:		
City:	State:	Zip:	Office Street Add	Office Street Address:		
Phone:			City:	State:	Zip:	
Medication Information (required)						
Medication Name:			Strength:	·	Dosage Form:	
☐ Check if requesting brand			Directions for Us	Directions for Use:		
☐ Check if request is for continuation of therapy						
Clinical Information (required)						
Select the diagnosis below:						
□ Short bowel syndrome □ Other diagnosis: ICD-10 Code(s):						
Clinical information:						
Is Zorbtive prescribed by or in consultation with a gastroenterologist? Yes No						
Is the patient receiving specialized nutritional support (i.e., parenteral nutrition)? Yes No						
Does the patient have acute critical illness due to complications following open heart surgery, abdominal surgery, multiple accidental trauma, or acute respiratory failure? Yes No						
Has the patient been screened to verify the absence of any active malignancy? Yes No						
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?						
	For urgent or expedite	denied unless all required inforr ed requests please call 1-855-4 d for non-urgent requests and f	01-4262.			

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.

Office use only: Zorbtive_SouthDakotaMedicaid_2017May