HEALTHCARE REFORM COPAY WAIVER REQUEST FORM*

Fax completed form to **888.610.1180** or email to **PASupport@RxBenefits.com**

: This request form is ONLY for requesting copay waivers for medications in the same class as a medication on the OptumRx healthcare reform preventative drug list. For prior authorization requests, please complete the form found here: **www.rxbenefits.com/prior-authorization-form/*

Request Date: □ Request to expedite review

If the prescriber attests that applying the standard turnaround time could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request, please mark above the request to expedite this review process.

Patient Information			Prescriber Information		
Member Name:			Prescriber Name		
Date of Birth:	□ Male □ Female		NPI:	Specialty:	
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone Number:			Phone Number:		
Member ID			Fax Number (in HIPAA compliant area):		

Medication Information

Medication Name and Strength:	□ Check if request is for brand name only
Directions for Use:	Quantity / day supply:
	□ New Therapy □ Continuation of Therapy

ICD 10 codes(s) and diagnosis for use of medication:

What medication(s) has the patient previously tried and failed for their condition due to inadequate response or intolerance? (Please list ALL medications, duration of trials, and reasons for discontinuation)

What medication(s) utilized for the patient's condition does the patient have a contraindication to? (Please list all relevant medications and the specific, labeled contraindication for use that the patient has)

Please list and/or attach documentation of any other medical information that the prescriber feels is relevant to this request:

The prescriber attests that the provided information is complete and accurate and understands that RxBenefits, Inc. reserves the right to perform an audit requesting the medical information necessary to verify accuracy at any time.

Prescriber Signature: Date: