Illinois certification of medical necessity form

For continued use of medication to be up-tiered or excluded

Submit this form electronically by visiting go.covermymeds.com/optumrx or mail it to:

Optum Rx
Prior Authorization Department
P.O. Box 2975
Mission, KS 66201

All fields are required.

Member information			**Provider information**		
Member name:			Provider name:		
Insurance ID:			National Provider Identifier (NPI) number:		Specialty:
Date of birth:			Office phone:		
Street address:			Office fax:		
City:	State:	ZIP code:	Office street address:		
Phone:			City:	State:	ZIP code:
Medication information					
Medication name:			Strength:		Dosage form:
Original start date of medication:			Same strength and dosage? Yes or No		
Prescriber attestation:					
The prescriber certifies that the medication and strength stated above for this member is medically necessary for their continued treatment. Prescriber signature: _____ Date: _____					

PCA-1-25-02016-E&I-FM_IL_xxxxxx25