



## Illinois certification of medical necessity form

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

Submit this form electronically by visiting [go.covermyrx.com/optumrx](https://go.covermyrx.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: _____		

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