



## Georgia Watch Form

**Note:** All of the following requests for information must be answered completely, correctly, and legibly, otherwise the authorization process **will be delayed.**

<b>Member Information</b> (required)			<b>Provider Information</b> (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:
<b>Medication Information</b> (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
<b>Clinical Information</b> (required)					
<b>What is the patient's diagnosis for the medication being requested?</b> _____					
ICD-10 Code(s): _____					
<b>Clinical information:</b>					
Generic products tried? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If <b>Yes</b> , list the names of the manufacturers of the generic products tried:					
1. _____ 2. _____ 3. _____					
What was the patient's response to each generic product? (A response description <b>MUST</b> be given)					
<u>Product Name</u>		<u>Response</u>			
1. _____		<input type="checkbox"/> Subtherapeutic Response <input type="checkbox"/> Allergy <input type="checkbox"/> Side Effect <input type="checkbox"/> Other			
<i>Response description:</i>					
2. _____		<input type="checkbox"/> Subtherapeutic Response <input type="checkbox"/> Allergy <input type="checkbox"/> Side Effect <input type="checkbox"/> Other			
<i>Response description:</i>					
3. _____		<input type="checkbox"/> Subtherapeutic Response <input type="checkbox"/> Allergy <input type="checkbox"/> Side Effect <input type="checkbox"/> Other			
<i>Response description:</i>					
<b>Any additional information pertaining to this drug request should be included and attached to this form.</b>					
<b>Physician Signature (required):</b> _____			<b>Date:</b> _____		
<b>Medical Office Contact:</b> _____			<b>Signature:</b> _____		

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

Please note: This request may be denied unless all required information is received.  
For urgent or expedited requests please call 1-866-525-5827.  
This form may be used for non-urgent requests and faxed to 1-888-491-9742.

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: GeorgiaWatchForm\_GAM\_2017Oct