PRIOR AUTHORIZATION REQUEST FORM

Humana®

EOC ID:
Universal

Phone: 1-800-555-2546 Fax to: 1-877-486-2621

Humana manages the pharmacy drug benefit for your patient. Certain requests for prior authorization require additional information from the prescriber. Please provide the following information and fax this form to the number listed above. **Information left blank or illegible may delay the review process.**

For Medicare Private-Fee-For-Service members, prior authorization is not required for medications covered under Part B. The information below is needed for a Part B versus Part D determination for these members.

Patient name:	**Prescriber name:**	
Member/subscriber number:	Fax:	Phone:
Patient date of birth:	Office contact:	
Group number:	NPI:	Tax ID:
Address:	Address:	
City, state, ZIP:	City, state, ZIP:	
	Specialty/facility name (if applicable):	

Drug name: Directions/SIG: Quantity:	☐ Expedited/exigent/urgent By checking this box, I certify an expedited/exigent/urgent review is required. The member has a health condition that may seriously jeopardize his/her life or ability to regain maximum function**. (Please include explanation of exigency in the space below.)**

Is this a proactive request for a new plan year? Yes____ No____ If yes, please provide plan year:_____

(Please note: All reviews will be processed with generic equivalents for brand drugs whenever possible.)

Please attach pertinent medical history or information for this patient that may support approval and sign this form.

Q1. Please provide additional information (e.g. chart notes, lab results) that would be pertinent to the review of the drug requested

Q2. Please provide diagnosis: *

Q3. Please provide J-Code, if applicable:

Q4. Please provide ICD Diagnostic Codes:

Q5. Please indicate where the drug is being dispensed? *

- ☐ Pharmacy dispensed to patient
- ☐ Pharmacy shipped to prescriber
- ☐ Prescriber dispensed
- ☐ Other

PRIOR AUTHORIZATION REQUEST FORM

Humana®

EOC ID:
Universal

Phone: 1-800-555-2546 Fax back to: 1-877-486-2621

Patient Name:	**Prescriber Name:**

Q6. If other, please specify: *

Q7. Please indicate if this request is a: *

☐ New start/ initial request ☐ Continuation/ reauthorization request

Prescriber signature

Date

I declare under penalty of perjury under the laws of the United States of America that the information provided is true and correct. This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately. 3149ALL0917-B