PRIOR AUTHORIZATION REQUEST FORM

Humana®

EOC ID:

Admin - State Specific Authorization Form 43

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

Humana manages the pharmacy drug benefit for your patient. Certain requests for coverage 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.**

Please reference Humana's coverage policy at http://apps.humana.com/tad/tad_new/home.aspx?type=provider for all clinical criteria.

Note: This fax form is for requests for a member/resident in accordance with state mandates.

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):

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

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

Please attach any pertinent medical history or information for this patient that may support approval. Provide the following information, sign this form and return it.

☐ 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. _____

Height: **Weight:** **Allergies:**

J-code (if applicable)	Drug name	Dose	Directions for use

Q1. Please provide diagnosis: *
Q2. Please provide J-code, if applicable:
Q3. Please provide ICD Diagnostic Codes:

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Patient Name:	**Prescriber Name:**

Q4. Is the drug being requested for use in an ongoing investigational trial (please provide trial name and registration number)?

☐ Yes ☐ No

Q5. Please provide location of treatment (e.g. MD office, facility, home health) including name and Tax ID#:

Q6. Is the request for a reauthorization?

☐ Yes ☐ No

Q7. Is the patient currently stable on therapy?

☐ Yes ☐ No

Q8. Please list all therapeutic alternatives previously used with start/end dates and outcome:

Q9. Please provide all relevant lab values related to the patient's medical conditions:

Q10. If the request is for duplicate therapy for the patient's health condition, please provide information and rationale for concomitant use of the medications:

Q11. Please provide dosing rationale for the requested quantity:

Q12. Please provide patient's complete current medication list:

Q13. Please provide all pertinent medical information related to the patient's diagnosis:

Q14. Please include any additional comments that would be of benefit to the review of this request:

Prescriber signature

Date