MEDICAL PRECERTIFICATION REQUEST FORM

Humana

EOC ID:
Administrative - Universal B vs D 40
Phone: 1-866-461-7273 Fax back to: 1-888-447-3430

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

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

If the patient is a Medicare private-fee-for-service patient, which of the following applies?

I am giving notification. Yes____ No____

I am requesting an advanced coverage determination. Yes____ No____

☐ By checking this box, I am requesting multiple drug reviews for this patient.

Expedited/exigent/urgent

☐ By checking this box, I certify an expedited/exigent/urgent review is required. The patient 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.)**

Drug name and strength:	Dose per infusion/injection:
Directions/SIG:	Number of infusions/injections:
Quantity/units:	Number of cycles/frequency:

Is this a request for services already provided? Yes ___ No ___

If yes, please provide date of service: __/__/____

(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 diagnosis: *
Q2. Please provide J-Code, if applicable:
Q3. Please provide ICD Diagnostic Codes:
Q4. Please indicate which one of the following applies: * ☐ The drug is billed, dispensed and administered by: physician, physician-based infusion clinic, or hospital-based

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Patient Name:	**Prescriber Name:**

infusion clinic on patient's behalf
☐ The drug is billed and shipped from a retail/specialty pharmacy on patient's behalf to the physician's office or facility (non-self-administered infusible drug)
☐ The drug is dispensed to the patient by a retail/specialty pharmacy
☐ Home health service (supplied and administered)
☐ Long Term Care (supplied and administered)
☐ Skilled Nursing Facility (supplied and administered)

Q5. If a resident in a skilled nursing facility or a facility that administers skilled care, is the patient's stay covered by Part A?

☐ Yes ☐ No

Q6. Will the drug be administered by an implantable infusion pump? *

☐ Yes ☐ No

Q7. Will the drug be administered by an external infusion pump? *

☐ Yes ☐ No

Q8. If the drug will be administered by an external infusion pump, please indicate if one of the following applies: *

☐ Administered in a home setting
☐ Administered in an assisted living facility
☐ The patient resides in one of the following long-term care (LTC) facilities: A nursing home that is dually-certified as both a Medicare (SNF) and a Medicaid nursing facility (NF); OR A Medicaid-only NF that primarily furnishes skilled care; OR A non-participating nursing home (i.e. neither Medicare nor Medicaid) that provides primarily skilled care; OR An institution which has a distinct part SNF and which also primarily furnishes skilled care

Q9. **For facilities other than the prescriber's office, please provide where the drug will be obtained and administered:

Q10. Is the drug requested part of a clinical trial?

☐ Yes ☐ No

Q11. If yes, please provide the registration or identification number for the specific trial for which this drug is being studied (e.g. ClinicalTrials.gov Identifier: NCT12345678): *

Q12. Please indicate if this request is a: *

☐ New start/ initial request ☐ Continuation/ reauthorization request

Q13. Additional Comments:

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Patient Name:	**Prescriber Name:**

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 to arrange for the return of this document. LC3035ALL1019 2020-05-07