MEDICAL PRECERTIFICATION REQUEST FORM

Humana®

EOC ID:
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:**
	Fax:
Member/subscriber number:	Phone:
Patient date of birth:	Office contact:
	Tax ID:
Group number:	NPI:
Address:	Address:
City, state and ZIP code: ,	City, state and ZIP code: ,
	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 their 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:

Please provide date of service: __/__/____ (Note: If no date is specified, the date the request was received will be utilized.)

(Note: All reviews will be processed with generic equivalents for brand-name 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: *

MEDICAL PRECERTIFICATION REQUEST FORM

Humana®

EOC ID:
Universal B vs D 40

Phone: 1-866-461-7273 Fax back to: 1-888-447-3430

Patient Name:	**Prescriber Name:**

- ☐ Prescriber supplied
- ☐ Pharmacy shipped to prescriber
- ☐ Pharmacy dispensed to patient
- ☐ Supplied by pharmacy and administered in home health service, long term care, or skilled nursing facility

Q5. Will the drug be administered by an implantable infusion pump? *

☐ Yes ☐ No

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

☐ Yes ☐ No

Q7. 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

Q8. Is the drug requested part of a clinical trial?

☐ Yes ☐ No

Q9. 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): *

Q10. Please indicate if this request is a: *

☐ New start/ initial request ☐ Continuation/ reauthorization request

Q11. For chemotherapy requests, please provide all antineoplastic medications being used in the chemotherapeutic regimen:

Q12. For chemotherapy requests, please provide all pertinent information to the review regarding the patients cancer staging, tumor grading, and/or TNM classification (or chart notes that may contain this information) if available:

Q13. For chemotherapy requests, please provide which line of chemotherapy this represents for the patient (eg. first line, second line, etc.):

Q14. Additional Comments:

MEDICAL PRECERTIFICATION REQUEST FORM

Humana®

EOC ID:
Universal B vs D 40

Phone: 1-866-461-7273 Fax back to: 1-888-447-3430

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.