



MEDICAL PRECERTIFICATION REQUEST FORM

EOC ID:

Botulinum Toxin (Botox, Dysport, Myobloc, Xeomin) 56
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 indicate if this request is a: *
<input type="checkbox"/> New start/initial request <input type="checkbox"/> Continuation/ reauthorization request
Q2. Please provide diagnosis: *
Q3. Please provide J-Code, if applicable:
Q4. Please provide ICD Diagnostic Codes:



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Patient Name:

Prescriber Name:

Q5. Is the drug requested part of a clinical trial?

Yes

No

Q6. 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): _____ *

Q7. Please indicate where the drug is being dispensed? *

Pharmacy dispensed to patient

Pharmacy shipped to prescriber

Prescriber dispensed

Other

Q8. If other, please specify: *

Q9. Will the requested drug be used for cosmetic purposes? *

Yes

No

Q10. Additional Comments:

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 2019-11-22