MEDICAL PRECERTIFICATION REQUEST FORM

Humana®

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: *

☐ New start/initial request ☐ Continuation/ reauthorization request

Q2. Please provide diagnosis: *

Q3. Please provide J-Code, if applicable:

Q4. Please provide ICD Diagnostic Codes:

MEDICAL PRECERTIFICATION REQUEST FORM

Humana®

EOC ID:
Botulinum Toxin (Botox,Dysport,Myobloc,Xeomin) 56
Phone: 1-866-461-7273 Fax back to: 1-888-447-3430

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