Humana®

UNIFORM PHARMACY PRIOR AUTHORIZATION REQUEST FORM

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete this form in its entirety and send to:

Plan/medical group phone number: 1-800-555-2546

Plan/medical group fax number: 1-877-486-2621

☐ **Urgent** [1]	☐ **Non-Urgent**

Requested Drug Name:		
Is this drug intended to treat opioid dependence?	**Yes** ☐	**No** ☐
If **Yes,** is this a first request for prior authorization for this drug? *** If Yes, prior authorization is not required. No need to complete this form.**	**Yes*** ☐	**No** ☐
If **No,** what was the date of the first request? Date: *** If greater than twelve (12) months since the first request, prior authorization request form is not required.**		

Patient Name:	Prescriber Name:
Member/Subscriber Number:	Prescriber Fax:
Policy/Group Number:	Prescriber Phone:
Patient Date of Birth (MM/DD/YYYY):	Prescriber Pager:
Patient Address:	Prescriber Address:
Patient Phone:	Prescriber Office Contact:
Patient Email Address:	Prescriber NPI:
	Prescriber DEA:
Prescription Date:	Prescriber Tax ID:
	Specialty/Facility Name (If applicable):
	Prescriber Email Address:

Prior Authorization Request for Drug Benefit:	New Request Reauthorization
Patient Diagnosis and ICD Diagnostic Code(s):	
Drug(s) Requested (with J-Code, if applicable):	
Strength/Route/Frequency:	

Unit/Volume of Named Drug(s):
Start Date and Length of Therapy:
Location of Treatment: (e.g. provider office, facility, home health, etc.) including name, Type 2 NPI (if applicable), address and tax ID:
Clinical Criteria for Approval, Including other Pertinent Information to Support the Request, other Medications Tried, Their Name(s), Duration, and Patient Response:

For use in clinical trial? (If yes, provide trial name and registration number):		
Drug Name (Brand Name and Scientific Name)/Strength:		
Dose:	Route:	Frequency:
Quantity:	Number of Refills:	
Product will be delivered to: ☐ Patient's Home ☐ Physician Office ☐ Other:		
Prescriber or Authorized Signature:		Date:
Dispensing Pharmacy Name and Phone Number:		

Approved **Denied**
If denied, provide reason for denial, and include other potential alternative medications, if applicable, that are found in the formulary of the carrier:

1. A request for prior authorization that if determined in the time allowed for non-urgent requests could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; could subject the person to severe pain that cannot be adequately managed without the drug benefit contained in the prior authorization request; or is a prior authorization request for medication-assisted treatment for substance abuse disorders. 2020-01-01