TEXAS STANDARDIZED PRIOR AUTHORIZATION REQUEST FORM FOR PRESCRIPTION DRUG BENEFITS

SECTION I — SUBMISSION

Submitted to: Humana	Phone: 1-866-461-7273	Fax: 1-888-447-3430	Date:

SECTION II — REVIEW

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

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Signature of Prescriber or Prescriber's Designee

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Address:	City, State, ZIP code		
Issuer Name (if different from Section I):	Member or Medicaid ID #:	Group #:	
BIN # (if available)	PCN (if available)	Rx ID# (if available)	

SECTION IV — PRESCRIBER INFORMATION

Name:		NPI#:	Specialty:
Address:		City, State, ZIP code	
Phone:	Fax:	Office Contact Name:	Contact Phone:

SECTION V — PRESCRIPTION DRUG INFORMATION

Requested Drug Name		Strength	Route of Administration
Quantity	Days' Supply	Expected Therapy Duration	**If this is a compound drug, identify all ingredients in Section VI, below.**
To the best of your knowledge this medication is: ☐ New therapy ☐ Continuation of therapy (approximate date therapy initiated:)			
For Provider Administered Drugs only, enter: HCPCS Code: NDC# Dose Per Administration			

SECTION VI — PRESCRIPTION COMPOUND DRUG INFORMATION

Compound Drug Name			
Ingredients and NDC#s	Quantity of each ingredient	Ingredients and NDC#s	Quantity of each ingredient

SECTION VII — PRESCRIPTION DEVICE INFORMATION

Requested Device Name	Expected Duration of Use
If applicable, enter HCPCS Code	

SECTION VIII — PATIENT CLINICAL INFORMATION

Patient's diagnosis related to this request:	ICD Version:	ICD Code:

Drugs patient has taken for this diagnosis: (Provide the following information to the best of your knowledge.)

Drug Name, Strength and Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug allergies:	Height (if applicable):
	Weight (if applicable):

Attach or list below relevant laboratory values and dates:

Date	Test	Value

SECTION IX — JUSTIFICATION (SEE INSTRUCTION PAGE SECTION IX)