MEDICAL PRECERTIFICATION REQUEST FORM

Humana®

EOC ID:
Lemtrada, Ocrevus, Tysabri 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 provide if any of the following diagnoses apply: *

- ☐ relapsing form of Multiple Sclerosis
- ☐ primary progressive Multiple Sclerosis
- ☐ other

Q2. If other, please specify: *

Q3. Please provide J-Code, if applicable:

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Q4. Please provide ICD Diagnostic Codes:

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 if this request is a: *

☐ New start/initial request ☐ Continuation/ reauthorization request

Q8. Please indicate where the drug is being dispensed? *

☐ Pharmacy dispensed to patient
☐ Pharmacy shipped to prescriber
☐ Prescriber dispensed
☐ Other

Q9. If other, please specify: *

Q10. Is the request for: *

☐ Lemtrada
☐ Ocrevus
☐ Tysabri
☐ None of the above

Q11. Will Tysabri be used as monotherapy?

☐ Yes ☐ No

Q12. For Tysabri only, does the patient currently have or has had progressive multifocal leukoencephalopathy (PML)?

☐ Yes ☐ No

Q13. For Ocrevus only, does the patient have an active hepatitis B infection?

☐ Yes ☐ No

Q14. Additional Comments:

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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. LC3035ALL1019 2019-12-20