MEDICAL PRECERTIFICATION REQUEST FORM

Humana®

EOC ID:
AHCA MIT Viscosupplemental Agents 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 member, which of the following apply?

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.

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 diagnosis: *

Q2. Please provide J-Code, if applicable:

Q3. Please provide ICD Diagnostic Codes:

Q4. Is the drug requested part of a clinical trial?

☐ Yes ☐ No

Q5. 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):_____

Q6. Please indicate where the drug is being dispensed? *

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

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Q7. If other, please specify:

Q8. Please indicate if this request is a: *

☐ New start/ initial request ☐ Continuation/ reauthorization request

Q9. Does the patient have documented symptomatic osteoarthritis of the knee and therapy is limited to the knee? *

☐ Yes ☐ No

Q10. Additional comments:

Prescriber signature

Date