MEDICAL PRECERTIFICATION REQUEST FORM

Humana®

EOC ID:
Epogen, Retacrit (epoetin alfa) 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. Please indicate if this request is a: *

☐ New start/ initial request ☐ Continuation/ reauthorization request

Q8. Does the patient have a previous trial, contraindication, or intolerance to Procrit (epoetin alfa) or Aranesp (darbepoetin alfa)? *

☐ Yes ☐ No

Q9. Please provide the patient's most recent hemoglobin level: *

Q10. Is the hemoglobin level from lab values taken within the past 2 months? *

☐ Yes ☐ No

Q11. Please provide the patient's most recent Transferrin saturation percent: *

Q12. Is the Transferrin saturation percent from lab values taken within the past 2 months? *

☐ Yes ☐ No

Q13. Please provide the patient's Serum ferritin level: *

Q14. Is the Serum Ferritin level from lab values taken within the past 2 months? *

☐ Yes ☐ No

Q15. Does the patient have a history of iron or folate deficiency, hemolysis, or gastrointestinal bleeding? *

☐ Yes ☐ No

Q16. Does the patient have a diagnosis of anemia associated with Chronic Kidney Disease (CKD)? *

☐ Yes ☐ No

Q17. Is the patient on dialysis?

☐ Yes ☐ No

Q18. Is the patient receiving home dialysis?

☐ Yes ☐ No

Q19. Does the patient have a diagnosis of anemia associated with chemotherapy? *

☐ Yes ☐ No

Q20. Is the patient currently on or will be initiating chemotherapy?

☐ Yes ☐ No

Q21. Is the hemoglobin level sufficient to avoid transfusion?

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☐ Yes ☐ No

Q22. Does the patient have a diagnosis of anemia associated with HIV? *

☐ Yes ☐ No

Q23. Is the request to reduce the need for allogenic blood transfusions in an anemic patient scheduled to undergo elective, noncardiac, nonvascular surgery? *

☐ Yes ☐ No

Q24. Is the patient willing to donate blood?

☐ Yes ☐ No

Q25. Is the patient receiving iron supplementation?

☐ Yes ☐ No

Q26. Additional comments:

Prescriber signature

Date