



MEDICAL PRECERTIFICATION REQUEST FORM

EOC ID:

Viscosupplements 108

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 therapy being billed, dispensed and administered by: physician, physician-based infusion clinic, or hospital-based infusion clinic on patient's behalf? *
<input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. Is the therapy requested part of a clinical trial?
<input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Please indicate if this request is a: *
<input type="checkbox"/> New start/ initial request <input type="checkbox"/> Continuation/ reauthorization request
Q7. For a reauthorization request, has the patient had documented improvement with viscosupplemental therapy? *
<input type="checkbox"/> Yes <input type="checkbox"/> No



MEDICAL PRECERTIFICATION REQUEST FORM

EOC ID:
Viscosupplements 108

Phone: 1-866-461-7273 Fax back to: 1-888-447-3430

Patient Name:	Prescriber Name:
Q8. For a reauthorization request, have six months passed since last treatment cycle? *	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Does the patient have documented symptomatic osteoarthritis of the knee and therapy is limited to the knee? *	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Has there been inadequate response to conservative nonpharmacologic treatments such as education, strengthening and range of motion exercises, assisted devices and weight loss? *	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Has the patient had previous treatment, contraindication, or intolerance to simple analgesic therapy (e.g. acetaminophen, NSAID, narcotics, salicylates) or intraarticular corticosteroids (e.g. triamcinolone, methylprednisolone, betamethasone, dexamethasone)? *	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. Additional Comments:	

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. 3149ALL0917-J 2020-1-1