MEDICAL PRECERTIFICATION REQUEST FORM

Humana®

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? *

☐ Yes ☐ No

Q5. Is the therapy requested part of a clinical trial?

☐ Yes ☐ No

Q6. Please indicate if this request is a: *

☐ New start/ initial request ☐ Continuation/ reauthorization request

Q7. For a reauthorization request, has the patient had documented improvement with viscosupplemental therapy? *

☐ Yes ☐ No

MEDICAL PRECERTIFICATION REQUEST FORM

Humana®

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? *

☐ Yes ☐ No

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

☐ Yes ☐ 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? *

☐ Yes ☐ 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)? *

☐ Yes ☐ No

Q12. Additional Comments:

Prescriber signature

Date