Humana®

Humana Clinical Pharmacy Review
P.O. Box 33008
Louisville, KY 40232-3008

Date: _____

Drug Prior Authorization Request Form

Fax completed form to 1-877-486-2621

Prior authorization phone line: 1-800-555-2546

Patient information (required):

Name: _____

DOB: _____

Nine-digit HFS ID number: _____

Prescriber information (required):

Name: _____

Phone: _____

Fax: _____

NPI #: _____

Pharmacy information:

Pharmacy name: _____

Phone: _____

Fax: _____

NPI #: _____

Contact person for this request (required):

Name: _____

Phone: _____ Ext.: _____

Fax: _____

Clinical information

1. Medication: _____ Strength: _____ Dosage form: _____

NDC (if available): _____ Quantity: _____ Days' supply: _____ Refills: _____

Start date of this request: _____ Dosing frequency: _____ Duration of therapy: _____

2. ICD-10 code/diagnosis: _____

3. List **all** medications previously tried for this indication and provide reason for failure (e.g., side effects, intolerance):

4. Clinical justification for requesting this drug versus one that does not require prior authorization:

5. Will any current drugs for this diagnosis be discontinued if this drug is approved? If so, please list below:

If you are requesting an override of a specific limitation, please indicate by checking the appropriate box:

☐ Age ☐ Daily dose ☐ Brand name ☐ Three brand limit

☐ Sex ☐ Maximum/minimum quantity ☐ Emergency 72-hour supply

Provider's signature: _____ Date: _____