Humana.

Humana Medical Intake Team

Date _____

Drug Prior Authorization Request Form

Fax completed form: 1-888-447-3430 Prior Authorization phone line**:** 1-866-461-7273

Patient Information (required):	**Prescriber Information (required):**
Name:_____	Name:_____
DOB: _____	Phone:_____
Nine-Digit HFS ID Number: _____	Fax: _____
	NPI #: _____
Pharmacy Information:	**Contact person for this request (required):**
Pharmacy Name: _____	Name:_____
Phone:_____	Phone:_____ Ext.:_____
Fax: _____	Fax: _____
NPI #: _____	

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:_____