

ARIZONA STANDARDIZED PRIOR AUTHORIZATION REQUEST FOR MEDICATION, DME, AND MEDICAL DEVICE

SECTION I – SUBMISSION

Subscriber Name:	Phone:	Fax:	Date:
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SECTION II – REASON FOR REQUEST

Check one:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Continuation/Renewal Request
Reason for request: (check all that apply)		<input type="checkbox"/> Prior Authorization
<input type="checkbox"/> Step Therapy, Formulary Exception		<input type="checkbox"/> Medical Device
<input type="checkbox"/> Quantity Exception		<input type="checkbox"/> Durable Medical Equipment (DME)
<input type="checkbox"/> Specialty Drug		<input type="checkbox"/> Other (please specify) _____

SECTION III – REVIEW

<input type="checkbox"/>	Expedited/Urgent Review Requested: By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient’s ability to regain maximum function.
Signature of Prescriber or Prescriber’s Designee: _____	

SECTION IV – PATIENT INFORMATION

Name:	Phone:	DOB:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address:	City:	State:	ZIP Code:	
Subscriber Name (if different from Section I):	Member ID #:	Group Name or Number:		
BIN # (if available):	PCN (if available):	Rx ID # (if available):		

SECTION V – PRESCRIBER/ORDERING PROVIDER INFORMATION

Name:	NPI #:	Specialty:		
Address:	City:	State:	ZIP Code:	
Phone:	Fax:	Office Contact Name:	Contact Phone:	

SECTION VI – PRESCRIPTION DRUG INFORMATION

(If this is a compound drug, identify all ingredients in Section VI, below.)

Requested Drug Name:				
Strength:	Route of Administration:	Quantity:	Days’ Supply:	Expected Therapy Duration:
To the best of your knowledge this medication is:				
<input type="checkbox"/> New therapy <input type="checkbox"/> Continuation of therapy (approximate date therapy initiated: _____)				
For Provider Administered Drugs Only:				
HCPCS Code: _____ NDC #: _____ Dose Per Administration: _____				

Insurer Contact and Submission Information

Humana Clinical Pharmacy Review
P.O. Box 33008
Louisville, KY 40232-3008
Fax completed form to 1-877-486-2621

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

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SECTION VII — PRESCRIPTION COMPOUND DRUG INFORMATION

Compound Drug Name:					
Ingredient	NDC #	Quantity	Ingredient	NDC #	Quantity

SECTION VIII — PRESCRIPTION DME or MEDICAL DEVICE INFORMATION

Requested DME or Medical Device Name:	Expected Duration of Use:	HCPCS Code (If applicable):
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SECTION IX — PATIENT CLINICAL INFORMATION

Patient's diagnosis related to this request:	ICD Version:	ICD Code:
Patient's diagnosis related to this request:	ICD Version:	ICD Code:

Drugs patient has taken for this diagnosis: *(Provide the following information to the best of your knowledge)*

Drug Name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug Allergies:	Height (if applicable):	Weight (if applicable):
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Relevant laboratory values and dates (attach or list below):

Date	Test	Value

SECTION X — JUSTIFICATION (Provide or attach any additional justification here: Notes, Treatment plans, lab/test results, etc)

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