Humana

Medicare Advantage and Dual Eligible Special Needs Plans
Prior authorization and Notification List

After reading the applicability of the prior authorization requirements below, access services, codes and medication by selecting the appropriate link:

Medicare October 2025 Medical (physical health)/ Behavioral health prior authorization list, please click here

Medicare 2025 Provider Administered Medication prior authorization list, please click here

We have updated our prior authorization and notification list for Humana Medicare Advantage (MA) and Dual Eligible Special Needs (D-SNP) plans.

Please note that the term "prior authorization" (preauthorization, precertification, preadmission), when used in this communication, is defined as a process through which the physician or other healthcare provider is required to obtain advance approval from the plan as to whether an item or service will be covered.

"Notification" refers to the process by which the physician or other healthcare provider notifies Humana of the intent to provide an item or service. Humana requests notification, as it helps coordinate care for Humana-covered patients. This process is distinguished from prior authorization. Humana does not issue an approval or denial for notifications.

The list details services and medications (i.e., medications that are delivered in the physician's office, clinic, outpatient or home setting) that require prior authorization prior to being provided or administered. Services must be provided according to Medicare coverage guidelines, established by the Centers for Medicare & Medicaid Services (CMS). According to the guidelines, all medical care, services, supplies and equipment must be medically necessary. You can review Medicare coverage guidelines here.

To view Humana's medical coverage policies, please visit.

Investigational and experimental procedures and devices usually are not covered benefits. Please consult the patient's Evidence of Coverage or contact Humana for confirmation of coverage.

Please note that certain services may not be covered under the member's plan.

Important notes:

- **Humana MA health maintenance organization (HMO):** The full list of prior authorization requirements applies to patients with Humana MA HMO and HMO point-of-service (HMO POS) coverage. Healthcare providers who participate in an independent physician

association (IPA) or other risk network with delegated services are subject to the prior authorization list and should refer to their IPA or risk network for guidance on processing their requests. Exclusions may change, so please refer to Provider.Humana.com for the most up-to-date information**. Choose "Authorization & Referrals" at the bottom of the page and then the appropriate topic.**

- **Florida MA HMO:** The full list of prior authorization requirements applies to Florida MA HMO-covered patients. Healthcare providers should submit requests directly to Humana for medications listed on the MA and D-SNPs Medication Prior authorization Drug List for all patients with Humana MA HMO coverage in Florida. If Humana does not receive a prior authorization request, the claim may be reviewed retrospectively for medical necessity, and the healthcare provider may be contacted for clinical information. See "How to Request Prior authorization" for instructions on how to submit prior authorization requests for medications on the MA and D-SNPs Medication Prior authorization List.
- **Humana MA private fee-for-service (PFFS):** Prior authorization is not required for MA PFFS plans. However, notification is requested, as it helps coordinate care for Humana-covered patients. Physicians and healthcare providers can request an advance coverage determination, or ACD (for review and determination of coverage in advance of the services being provided), on behalf of the patient for any service not on our prior authorization list. See "Advance Coverage Determinations" for instructions.
- **Humana MA preferred provider organization (PPO**): The full list of prior authorization requirements applies to patients with Humana MA PPO coverage.
- **Humana Medicare Supplement plan:** This list does not apply to policyholders of a Humana Medicare Supplement plan.
- **Humana commercial:** This list does not affect Humana commercial plans. (Find Humana's Commercial Prior authorization and Notification List on our prior authorization page at Humana.com/PAL.)
- **All Humana MA plans** – For procedures or services that are investigational or experimental (or that may have limited benefit coverage), or to learn if Humana will pay for a service, you can request an ACD on behalf of the patient prior to providing the service. You may be contacted if additional information is needed.
    - ACDs for medical services can be initiated by submitting a written, fax or telephone request:
        - Mail written requests to:
          Humana Correspondence
          P.O. Box 14601
          Lexington, KY 40512-4601
        - Submit by fax to 800-266-3022.
        - Submit by telephone at 800-523-0023.
    - ACDs for medications on the list can be initiated by submitting a fax or telephone request:
        - Submit by fax to 888-447-3430.
        - Submit by telephone at 866-461-7273.

    - To prevent disruption of care, Humana does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to enrollment. Humana may review services furnished during an active course of treatment against permissible coverage criteria

when determining payment. To ensure appropriate claim payment, please include the modifier based on Humana's Medicare Advantage Payment Policy (CP2023011), found on Humana.com, or include medical records with evidence the member is in an active course of treatment.

Please note that urgent/emergent services do not require referrals or prior authorizations.

Not obtaining prior authorization for a service could result in financial penalties for the practice and reduced benefits for the patient based on the healthcare provider's contract and the patient's Certificate of Coverage. Services or medications provided without prior authorization may be subject to retrospective medical necessity review. We recommend that an individual practitioner making a specific request for services or medications verify benefits and prior authorization requirements with Humana prior to providing services.

New rule improves the prior authorization process

Effective January 1, 2026, the Centers for Medicare and Medicaid Services (CMS) requires prior authorization decisions within 7 days for requests for medical items/services.

Accordingly, supporting clinical information must be submitted at the time of prior authorization requests. Failure to do so may result in a delayed or adverse decision.

Adherence to this process should begin immediately.

Learn more

Information required for a prior authorization request or notification may include, but is not limited to, the following:

- Member's Humana ID number, name and date of birth
- Date of actual service or hospital admission
- Procedure codes (up to a maximum of 10 per authorization request)
- Date of proposed procedure (if applicable)
- Diagnosis codes (primary and secondary) (up to a maximum of 6 per authorization request)
- Service location
- Inpatient (acute hospital, skilled nursing or hospice)
- Outpatient (telehealth, office, home, off-campus outpatient hospital, on-campus outpatient hospital or ambulatory surgery center [ASC])
- Referral (office, off-campus outpatient hospital, on-campus outpatient hospital, ASC, other)
- Tax Identification Number (TIN) and National Provider Identifier (NPI) number of treatment facility where service is being rendered
- TIN and NPI number of the provider performing the service
- Caller/requestor's name/telephone number
- Attending physician's telephone number
- Relevant clinical information
- Discharge plans

Submitting all relevant clinical information at the time of the request will help expedite determination. If additional clinical information is required, a Humana representative will request the specific information needed to complete the authorization process.

How to request prior authorization:
Except where noted via links on the following pages, prior authorization requests for medical services may be initiated:

- Online at www.availity.com (registration required)
- By calling Humana's interactive voice response line at 800-523-0023

Please note: Online prior authorization requests are encouraged. For certain PAL services requested via Availity, healthcare providers have an option to complete a questionnaire. Answers to the questionnaire could lead to real-time approval. If approval is not provided immediately, the information on the questionnaire may help Humana with the review.

Except where noted via links on the following pages, prior authorization for **medications** may be initiated:

- By sending a fax to 888-447-3430 (request forms are available at **Humana.com/Medpa**)
- By calling 866-461-7273, **M**onday – Friday, 8 a.m. – 11 p.m., Eastern time

This list is subject to change with notification; however, it may be modified throughout the year for additions of new-to-market medications or step therapy requirements for medications without notification via United States Postal Service mail.