Humana
Healthy Horizons in Virginia

PRIOR AUTHORIZATION REQUEST FORM

Universal

Phone: 800-555-2546 Fax: 877-486-2621

Humana manages the pharmacy drug benefit for your patient listed below. Certain requests for prior authorization require additional information from the provider. Please provide the following information and fax this form to the number listed above. Information not provided or illegible writing may delay the review process.

For Medicare private fee-for-service plan members, prior authorization is not required for medications covered under Medicare Part B. The information below is needed for a Medicare Part B versus Part D determination for these patients.

Patient name:	**Provider name:**
Member/subscriber number:	Fax:
Patient date of birth:	Phone:
Group number:	Office contact:
Address:	NPI: Tax ID:
City, state and ZIP code:	Address:
	City, state and ZIP code:
	Specialty/facility name (if applicable):

Drug name:	☐ **Expedited/exigent/urgent**
Directions/SIG:	By checking this box, I certify an expedited/exigent/urgent review is required. The patient has a health condition that may seriously jeopardize their life or the ability to regain maximum function. **(Please include explanation of exigency in the space below.)**
Quantity:	

(Please note: All reviews will be processed with generic equivalents for brand-name drugs whenever possible.)

Please attach pertinent medical history or information for this patient that may support approval and sign this form.

Q1. Please provide additional information (e.g., chart notes, lab results) that would be pertinent to the review of the drug requested:
Q2. Please provide diagnosis:*
Q3. Please provide HCPCS (if applicable):
Q4. Please provide ICD-10 diagnostic codes:

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Q5. Please indicate where the drug is being dispensed? *

- ☐ Pharmacy dispensed to patient
- ☐ Pharmacy shipped to provider
- ☐ Provider dispensed
- ☐ Other

Q6. If other, please specify: *

Q7. Please indicate if this request is a:*

- ☐ New start/initial request
- ☐ Continuation/ reauthorization request

Q8. Additional comments:

Provider signature

Date

I declare under penalty of perjury under the laws of the United States of America that the information provided is true and correct. This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately.