HUMANA.
Guidance when you need it most

Humana Clinical Pharmacy Review
1-877-486-2621 (Fax)
www.humana.com

Universal fax form for drug authorization

Patient Information				Physician Information			
Patient name:		Date of Birth:		Name:	TAX ID#:		
Sex: M ☐ F ☐	Home Phone: ( )	Work Phone: ( )		Address	City	State	Zip code
Subscriber ID#				Telephone: ( )	Fax: ( )		
Address	City	State	Zip code	Physician Specialty (if applicable):			
Medication administered (if injectable): ☐ Physician office Will physician supply the medication? ☐ Yes ☐ No ☐ Patient's home ☐ Other _____				**Physician signature (required):**	Date:		

Diagnosis and Medical Information	
Is this a reauthorization? Yes ☐ No ☐	State from which you are requesting this medication (**required**):
Diagnosis:	Therapeutic alternatives previously used (**required**): _____ _____ Please list outcomes from previous treatment: _____
ICD-9 Code: **J-Code:**	
Please provide any medical information which may support approval:	
Note: Medications may be subject to a quantity limitation sufficient for a 30 day supply per fill based on FDA approved dosages.	

Medication and Dose Requested
Medication requested:
Dosage:
Sig:

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

Please note any information left blank or illegible may delay the review process