

Fax completed form to: 1-866-868-0858  
Questions, please call: 1-866-316-6049



## Important Information About Prescription Drug Coverage

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Humulin R U-500® (Insulin regular 500 units/mL): Prior Authorization Request Form: Please respond.

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- Please complete the attached Humulin R U-500® (Insulin regular 500 units/mL) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

**Please note:** By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

### Information about this drug

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#### Humulin RU-500® (Insulin regular 500 units/mL)

Humulin R U-500® should be limited to diabetic patients with marked insulin resistance (requirements greater than 200 units/day). Humulin R U-500® is covered under the Medicare Part B DME benefit when used as a supply with an infusion pump in the home. Coverage under Part D is limited to certain long-term care facilities that do not qualify as the patient's home.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

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# Prior Authorization Request Form

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## Patient Information

Name \_\_\_\_\_  
Member ID \_\_\_\_\_  
Medicare ID \_\_\_\_\_  
Date of birth \_\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_  
Nursing home resident? YES / NO  
Home care patient? YES / NO

## Prescriber and Pharmacy Information

Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Pharmacy name \_\_\_\_\_  
NCPDP \_\_\_\_\_  
NPI \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

## All items below this line are for Physician Use Only

### Information for Requested Drug

Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill  
Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

### Humulin RU-500® (Insulin regular 500 units/mL) Criteria

- Please indicate Humulin RU-500®'s dispensing location:  
 pharmacy  
 physician's office, incident to a physician's service  
 other: \_\_\_\_\_
- Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed.  
 Type I Diabetes Mellitus (ICD-9: 250.01, 250.03)  
 Type II Diabetes Mellitus (ICD-9: 250.00, 250.02)  
 Other (diagnosis and ICD-9 code): \_\_\_\_\_
- Is the prescribing physician an endocrinologist or has an endocrinologist been consulted?  
 Yes  No
- Is the HbA1c reading > or = 9%?  
 Yes  No
- Is the patient receiving > 200 units of regular insulin/day?  
 Yes  No
- Please indicate Humulin RU-500 route of administration:  
 via SQ  via infusion pump
- If administered via infusion pump, please indicate where the patient resides:  
 At home OR An assisted living facility OR An intermediate care facility for the mentally retarded (ICF/MR).  
 long term care resident: Hospital or skilled nursing facility bed who does not have part A coverage, whose part A coverage has run out or whose stay is not covered OR A nursing home that is dually-certified as both a Medicare SNF and a Medicaid SNF OR A Medicaid-only NF that primarily furnishes skilled care OR A non-participating nursing home (i.e., neither Medicare or Medicaid) that provides primarily skilled care OR An institution which has a distinct part SNF which also primarily furnishes skilled care.  
 None of the above; please specify location: \_\_\_\_\_

Medical justification: (Attach additional page if necessary): \_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_