Humana Pharmacy®

Fax: 877-405-7940
Phone: 800-486-2668

Humana Specialty Pharmacy®

Monday – Friday: 8 a.m. – 11 p.m., Eastern time
Saturday: 8 a.m. – 6:30 p.m., Eastern time

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

Asthma and Allergy Prescription Form

Patient information

Patient: _____ ❒ Female ❒ Male DOB: _____ Insurance plan: _____ Plan ID #: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Home phone #: _____ Cell phone #: _____ Caregiver: _____ Caregiver phone #: _____

Other medical conditions: _____ Allergies: ❒ No ❒ Yes: _____

Clinical information

ICD-10 code: _____ Height: _____ Weight: _____ ❒ lb ❒ kg Date: _____

Additional information: Elevated blood eosinophil levels: (mark all that apply)

❒ ≥ 150 cells/mcL at therapy initiation ❒ ≥ 300 cells/mcL in the previous 12 months ❒ None listed

Previous therapies: ❒ _____ Present therapies: ❒ _____

Prescription information

Note: Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Medication	Directions	Quantity	Refills
❒ Cinqair 100 mg/10 mL vial ❒ 50 mL sodium chloride for injection	❒ Infuse____mg (3 mg/kg x ___kg) IV once every 4 weeks	❒ 28-day supply ❒ Other: _____	❒ 11 ❒ Other: ___
❒ Dupixent ❒ 200 mg/1.14 mL PFS ❒ 300 mg/2mL PFS ❒ 300 mg/2mL PEN	Initial dosing: ❒ Inject 400 mg SQ initially then 200 mg every other week ❒ Inject 600 mg SQ initially then 300 mg every other week	❒ 14-day supply	0
	Maintenance dosing: ❒ Inject 200 mg SQ every other week ❒ Inject 300 mg SQ every other week	❒ 28-day supply ❒ Other: _____	❒ 11 ❒ Other: ___
❒ Fasenra ❒30 mg/mL PFS ❒ 30 mg/mL auto-injector	Initial dosing: ❒ Inject 30 mg SQ every 4 weeks for the first 3 doses	❒ 84-day supply	0
	Maintenance dosing: ❒ Inject 30 mg SQ every 8 weeks	❒ 28-day supply ❒ Other: _____	❒ 11 ❒ Other: ___
❒ Nucala ❒ 100 mg vial ❒ 100 mg/mL auto-injector ❒ 100 mg/mL PFS	❒ Inject 100 mg under the skin every 4 weeks ❒ Inject 300 mg under the skin every 4 weeks ❒ Include sterile water and supplies QS per vial	❒ 28-day supply ❒ Other: _____	❒ 11 ❒ Other: ___
❒ Xolair ❒ 150 mg vial ❒ 75 mg/0.5mL PFS ❒ 150 mg/mL PFS	❒ Inject _____ under the skin every 4 weeks ❒ Inject _____ under the skin every 2 weeks ❒ Include sterile water and supplies QS per vial	❒ 28-day supply ❒ Other: _____	❒ 11 ❒ Other: ___
❒ Other: _____	_____ _____ _____	❒ _____	❒ _____

Prescriber and shipping information (please print)

Prescriber: _____ NPI: _____

Ship to: ❒ Patient ❒ Office ❒ Other: _____

Office address: _____ City: _____ State: _____ ZIP code: _____

Office phone number: _____ Office fax number: _____

Signature: _____ Date: _____

We will dispense this prescription as generic, unless the prescriber indicates "Dispense as Written" here: _____

The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form and fax language. Noncompliance with state-specific requirements could result in outreach to the prescriber.