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.

Hemophilia and Bleeding Disorders 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: ______________
Height: _____ Weight: _____ ❒ lb ❒ kg Date: ________ ICD-10 code: ________ Diagnosis: ______________ Date: ________

Clinical information

❒ Hereditary Factor VIII Deficiency: D66
❒ Hereditary Factor IX Deficiency: D67
❒ Hereditary Factor XI Deficiency: D68.1
❒ Von Willebrand's disease: D68.0
❒ Acquired hemophilia: D68.311
❒ ______________

Severity: ❒ Mild ❒ Moderate ❒ Severe
Target joint(s)? ❒ No ❒ Yes: ________
Venous access: ❒ PIV ❒ PICC ❒ Port
❒ Central line, type: ________
Inhibitor? ❒ No ❒ Yes: _____ BU
Doses to keep on hand: ________

Planned procedure:
❒ Dental extraction(s)
Date(s): ______________
❒ Surgical procedure(s)
Date(s): ______________

Prescription information

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

❒ Advate	❒ Adynovate	❒ Afstyla	❒ Alphanate	❒ AlphaNine SD	❒ Alprolix
❒ Fibryga	❒ BeneFix	❒ Corifact	❒ Eloctate	❒ Esperoct	❒ Feiba FS
❒ Ixinity	❒ Helixate FS	❒ Hemlibra	❒ Hemofil M	❒ Humate-P	❒ Idelvion
❒ Lysteda	❒ Jivi	❒ Kcentra	❒ Koate-DVI	❒ Kogenate FS	❒ Kovaltry
❒ Recombinate	❒ Novoeight	❒ NovoSeven RT	❒ Nuwiq	❒ Profilnine SD	❒ Rebinyn
❒ Xyntha	❒ Riastap	❒ Rixubis	❒ Tretten	❒ Vonvendi	❒ Wilate
❒ Other________					

❒ Prophylaxis (+/- 10% or other: _____) Dose: _____ ❒ IU ❒ IU/kg ❒ RCOF Frequency: ______________ # of doses: _____ Refills: _____
❒ Immune tolerance (+/- 10% or other: _____) Target dose: _____ ❒ IU ❒ IU/kg ❒ RCOF Frequency: ______________ # of doses: _____ Refills: _____

❒ Breakthrough bleed (+/- 10% or other: _____) Minor dose: _____ ❒ IU ❒ IU/kg ❒ RCOF Frequency: ______________ # of doses: _____ Refills: _____
Moderate dose: _____ ❒ IU ❒ IU/kg ❒ RCOF Frequency: ______________ # of doses: _____ Refills: _____
Major dose: _____ ❒ IU ❒ IU/kg ❒ RCOF Frequency: ______________ # of doses: _____ Refills: _____

❒ Hemlibra ❒ Initial dose: ❒ 3mg/kg ❒ ________ ❒ mg/kg ❒ mg
Directions: ______________
# of doses: _____ Refills: _____

❒ Subsequent dose: ❒ 1.5mg/kg ❒ 3mg/kg ❒ 6mg/kg ❒ ________ ❒ mg/kg ❒ mg
Directions: ______________
# of doses: _____ Refills: _____

❒ Skilled nursing visit to establish venous access, provide patient education related to therapy and disease state, administer medication as prescribed, and assess general status and response to therapy. Frequency based on prescription dose orders.

Additional medications/supplies	**Directions**	**Quantity**	**Refills**
❒ Amicar ❒ 500 mg tab. ❒ 1000 mg tab. ❒ 250 mg/mL sol.	______________	❒ ________	❒ _____
❒ desmopressin 4 mcg/mL inj.	______________	❒ ________	❒ _____
❒ heparin 100U/mL 5 mL PFS For central line patients.	Flush line with 5 mL, after final saline flush.	❒ ________	❒ _____
❒ lidocaine 2.5% and prilocaine 2.5% cream	Apply topically to needle insertion site, 30–60 minutes prior to insertion.	❒ ________	❒ _____
❒ sodium chloride 0.9% 10 mL flush	Flush line with 10 mL, before and after inf. and p.r.n. line care.	❒ ________	❒ _____
❒ Stimate 1.5 mg/mL sol.	______________	❒ ________	❒ _____
❒ tranexamic acid 650 mg tab.	______________	❒ ________	❒ _____

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.