

**Humana Specialty Pharmacy®**

Monday – Friday, 8 a.m. – 11 p.m., and  
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.

**Self-administered Rheumatology Prescription Form**

**Patient information**

Patient: \_\_\_\_\_  Female  Male DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  lb  kg Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_  
 Home phone #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_ Caregiver: \_\_\_\_\_ Caregiver phone #: \_\_\_\_\_  
 Other medical conditions: \_\_\_\_\_ Allergies:  No  Yes: \_\_\_\_\_  
 Insurance plan: \_\_\_\_\_ Plan ID #: \_\_\_\_\_ BIN: \_\_\_\_\_ PCN: \_\_\_\_\_ Group #: \_\_\_\_\_  
 \*Please send a copy of the patient's prescription insurance card if available.

**Clinical information**

ICD-10 code: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ Diagnosis date: \_\_\_\_\_  
 Concurrent medications: \_\_\_\_\_ Is the patient taking methotrexate?  No  Yes  
 Prior medications:  acetaminophen, ibuprofen or naproxen sodium  Azulfidine  Calcipotriene  Celebrex  corticosteroids  Enbrel  Humira  
 Indocin  Kevzara  methotrexate Justification for prior medications: \_\_\_\_\_  
 Has a physician ruled out hepatitis B?  Yes  No If "No," has a physician initiated treatment? \_\_\_\_\_ Date of negative TB test: \_\_\_\_\_

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

Medication	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Actemra	<input type="checkbox"/> 162 mg/0.9 mL PFS <input type="checkbox"/> 162 mg/0.9 mL ACTpen	<input type="checkbox"/> Inject 162 mg SQ every other week (weight < 100 kg) <input type="checkbox"/> Inject 162 mg SQ once a week (weight > 100 kg)	<input type="checkbox"/> 28-day supply	_____
<input type="checkbox"/> Cimzia	Initial dose: <input type="checkbox"/> Starter kit (200 mg PFS) <input type="checkbox"/> 200 mg vial	<input type="checkbox"/> Inject 400 mg SQ at weeks 0, 2 and 4	<input type="checkbox"/> 28-day supply	0
	Maintenance dose: <input type="checkbox"/> 200 mg/mL PFS <input type="checkbox"/> 200 mg vial	<input type="checkbox"/> Inject 400 mg SQ every four weeks <input type="checkbox"/> Inject 200 mg SQ every two weeks	<input type="checkbox"/> 28-day supply	_____
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 50 mg/mL PFS <input type="checkbox"/> 50 mg/mL SureClick <input type="checkbox"/> 50 mg/mL Mini cartridge <input type="checkbox"/> 25 mg/0.5 mL PFS <input type="checkbox"/> 25 mg vial	<input type="checkbox"/> Inject 50 mg SQ once a week <input type="checkbox"/> Inject 25 mg SQ twice a week	<input type="checkbox"/> 28-day supply	_____
<input type="checkbox"/> Humira	<input type="checkbox"/> 40 mg/0.8 mL pen <input type="checkbox"/> 40 mg/0.8 mL PFS <input type="checkbox"/> 40 mg/0.4 mL pen <input type="checkbox"/> 40 mg/0.4 mL PFS <input type="checkbox"/> 80 mg/0.8 mL pen	<input type="checkbox"/> Inject 40 mg SQ every other week <input type="checkbox"/> Inject 40 mg SQ once a week <input type="checkbox"/> Inject 80 mg SQ every other week	<input type="checkbox"/> 1 carton = 2 devices <input type="checkbox"/> 2 carton = 4 devices	_____
<input type="checkbox"/> Kevzara	<input type="checkbox"/> 200 mg/1.14 mL PFS <input type="checkbox"/> 150 mg/1.14 mL PFS <input type="checkbox"/> 200 mg/1.14 mL pen <input type="checkbox"/> 150 mg/1.14 mL pen	<input type="checkbox"/> Inject 200 mg SQ once every two weeks	<input type="checkbox"/> 28-day supply	_____
<input type="checkbox"/> Olumiant	<input type="checkbox"/> 1 mg tablet <input type="checkbox"/> 2 mg tablet	<input type="checkbox"/> Take 2 mg PO once daily	<input type="checkbox"/> 30-day supply	_____
<input type="checkbox"/> Orencia	<input type="checkbox"/> 250 mg vial <input type="checkbox"/> 125 mg/mL PFS <input type="checkbox"/> 125 mg/mL ClickJet	<input type="checkbox"/> Infuse _____ mg by IV for one dose. Then, inject 125 mg SQ weekly, starting within 24 hours of the IV dose <input type="checkbox"/> Inject 125 mg SQ once a week	<input type="checkbox"/> 28-day supply	_____
<input type="checkbox"/> Otezla	Initial dose: <input type="checkbox"/> Starter pack Day 1: 10 mg PO QAM; day 2: 10 mg PO QAM, 10 mg PO QPM; day 3: 10 mg PO QAM, 20 mg PO QPM; day 4: 20 mg PO QAM, 20 mg PO QPM; day 5: 20 mg PO QAM, 30 mg PO QPM; day 6 and thereafter: 30 mg twice daily, as indicated on the starter pack		<input type="checkbox"/> 1 starter pack	0
	Maintenance dose: <input type="checkbox"/> 30 mg tablet	<input type="checkbox"/> Take 30 mg PO twice daily	<input type="checkbox"/> 60 tablets	_____
<input type="checkbox"/> Rinvoq	15 mg ER tablet	<input type="checkbox"/> Take 15 mg PO once daily with or without food	<input type="checkbox"/> 30 tablets	_____
<input type="checkbox"/> Simponi	<input type="checkbox"/> 50 mg/0.5 mL PFS <input type="checkbox"/> 50 mg/0.5 mL SmartJect	<input type="checkbox"/> Inject 50 mg SQ once monthly	<input type="checkbox"/> One device	_____
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5 mg tablet	<input type="checkbox"/> Take 5 mg PO twice daily	<input type="checkbox"/> 60 tablets	_____
	<input type="checkbox"/> 11 mg XR tablet	<input type="checkbox"/> Take 11 mg XR PO once daily	<input type="checkbox"/> 30 tablets	_____

**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.