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.

Viscosupplement 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: ❒ NKDA ❒ Yes: _____

Height: _____ Weight: _____ ❒ lb ❒ kg Date: _____

Clinical information

ICD-10 code: _____ Diagnosis: _____ Diagnosis date: _____

Concurrent medications: _____

Expected date of first or next injection: _____

If applicable, please provide each previous therapy and its dates:

Therapy:	Discontinuation reason:	Dates:
❒ _____	_____	_____
❒ _____	_____	_____
❒ _____	_____	_____

Prescription information

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

Medication

❒ Durolane	20 mg/mL	3 mL PFS	❒ Hymovis	8 mg/mL	3 mL PFS	❒ Synvisc	8 mg/mL	2 mL PFS
❒ Euflexxa	10 mg/mL	2 mL PFS	❒ Monovisc	22 mg/mL	4 mL PFS	❒ Synvisc-One	8 mg/mL	6 mL PFS
❒ Gel-One	10 mg/mL	3 mL PFS	❒ Orthovisc	15 mg/mL	2 mL PFS	❒ Triluron	10 mg/mL	2 mL PFS
❒ Gelsyn-3	8.4 mg/mL	2 mL PFS	❒ sodium hyaluronate	10 mg/mL	2 mL PFS	❒ TriVisc	10 mg/mL	2.5 mL PFS
❒ GenVisc 850	10 mg/mL	2.5 mL PFS	❒ Supartz FX	10 mg/mL	2.5 mL PFS	❒ Visco-3	10 mg/mL	2.5 mL PFS
❒ Hyalgan	10 mg/mL	2 mL PFS						
❒ Hyalgan	10 mg/mL	2 mL vial						

Knee	Directions	Quantity	Refills
❒ Left ❒ Right ❒ Bilateral	_____ _____	❒ _____ syringes ❒ _____ vials	_____

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.