Humana Pharmacy®

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

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.

Pulmonary Arterial Hypertension 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:
- ❒ I27.0 primary pulmonary hypertension
- ❒ I27.2 secondary pulmonary hypertension
- ❒ _____

New York Heart Association functional classification: ❒ I ❒ II ❒ III ❒ IV
Six-minute walk distance: _____ meters
Is this patient on another therapy for pulmonary hypertension? ❒ No ❒ Yes
If "Yes," name of drug(s): _____
Attach copies of: ❒ History and physical ❒ Right heart catheterization ❒ Calcium channel blocker statement ❒ Echocardiogram

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
❒ Adcirca (tadalafil)	20 mg tablet	❒ Take two tablets once daily ❒ _____	_____	_____
❒ Letairis (ambrisentan)	Please complete a copy of the Ambrisentan REMS enrollment/consent form by accessing www.ambrisentanrems.us.com or calling **888-417-3172** and indicating Humana Specialty Pharmacy as your preferred pharmacy provider.			
	❒ 5 mg tablet ❒ 10 mg tablet	❒ Take one tablet daily ❒ _____	_____	_____
❒ Opsumit (macitentan)	Please complete a copy of the patient enrollment and consent form by accessing www.opsumitrems.com or calling **866-228-3546** and indicating Humana Specialty Pharmacy as your preferred pharmacy provider.			
❒ Revatio (sildenafil)	20 mg tablet	❒ Take one tablet three times daily ❒ _____	_____	_____
❒ Tracleer (bosentan)	Please complete a copy of the patient enrollment form by accessing www.bosentanremsprogram.com or calling **866-359-2612** and indicating Humana Specialty Pharmacy as your preferred pharmacy provider.			
	❒ 62.5 mg tablet ❒ 125 mg tablet ❒ 32 mg tablet for suspension	❒ Take 62.5 mg twice daily for four weeks, and then increase to 125 mg twice daily ❒ Take one tablet twice daily ❒ _____	_____	_____

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.