

## Humana Specialty Pharmacy<sup>®</sup>

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

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

### General Infusion Prescription Form

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

<b>Patient information</b>			
Patient: _____	<input type="checkbox"/> Female <input type="checkbox"/> Male	DOB: _____	Insurance plan: _____ Plan ID #: _____
Address: _____		City: _____	State: _____ ZIP code: _____
Home phone #: _____	Cell phone #: _____	Caregiver: _____	Caregiver phone #: _____
Other medical conditions: _____		Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____	
Height: _____	Weight: _____	<input type="checkbox"/> lb <input type="checkbox"/> kg	Date: _____

<b>Clinical information</b>	
ICD-10 code: _____	Diagnosis date: _____
Concurrent therapies: _____	First dose: <input type="checkbox"/> No <input type="checkbox"/> Yes
Previous therapies: _____	Expected date of first/next infusion: _____
Discontinuation reason: _____	Site of care: <input type="checkbox"/> Home <input type="checkbox"/> MDO <input type="checkbox"/> Clinic: _____
Date: _____	Venous access (for applicable therapies): <input type="checkbox"/> PIV <input type="checkbox"/> PICC <input type="checkbox"/> Port <input type="checkbox"/> Central line, type: _____
	Infusion method: <input type="checkbox"/> Gravity <input type="checkbox"/> Pump

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

Medications/supplies	Directions	Quantity	Refills
Dose: _____	_____	<input type="checkbox"/> 28-day supply <input type="checkbox"/> Other: _____	<input type="checkbox"/> 11 <input type="checkbox"/> Other: _____
Dose: _____	_____	<input type="checkbox"/> 28-day supply <input type="checkbox"/> Other: _____	<input type="checkbox"/> 11 <input type="checkbox"/> Other: _____

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.

Pretreatment: <input type="checkbox"/> acetaminophen <input type="checkbox"/> 325 mg tab. <input type="checkbox"/> 500 mg tab. <input type="checkbox"/> diphenhydramine <input type="checkbox"/> 25 mg cap. <input type="checkbox"/> 50 mg tab.	<input type="checkbox"/> Take _____ mg p.o. 30–60 min. prior to inf. and q4–6 p.r.n. Max. 4 doses in 24 hr. <input type="checkbox"/> _____	<input type="checkbox"/> 10 capsules <input type="checkbox"/> 10 tablets <input type="checkbox"/> _____	<input type="checkbox"/> 11 <input type="checkbox"/> _____
Anaphylactic treatment: <input type="checkbox"/> diphenhydramine <input type="checkbox"/> 50 mg/mL vial <input type="checkbox"/> 25 mg cap. <input type="checkbox"/> 50 mg tab.	<input type="checkbox"/> Infuse slowly IV p.r.n. anaphylaxis. <input type="checkbox"/> Take 25–50 mg p.o. p.r.n. anaphylaxis.	<input type="checkbox"/> 1 vial <input type="checkbox"/> 10 capsules <input type="checkbox"/> 10 tablets <input type="checkbox"/> _____	<input type="checkbox"/> 0 <input type="checkbox"/> _____
Anaphylactic treatment: <input type="checkbox"/> epinephrine <input type="checkbox"/> 0.3 mg auto-injector <input type="checkbox"/> 0.15 mg auto-injector - For patients weighing between 15–30 kg	Inject IM p.r.n. anaphylaxis.	<input type="checkbox"/> 2-pack <input type="checkbox"/> _____	<input type="checkbox"/> 0 <input type="checkbox"/> _____
<input type="checkbox"/> lidocaine 2.5% and prilocaine 2.5% cream	Apply topically to needle insertion site, 30–60 min. prior to insertion.	<input type="checkbox"/> 28-day supply <input type="checkbox"/> _____	<input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> lidocaine 2.5% and prilocaine 2.5% cream	Apply topically to needle insertion site, 30–60 min. prior to insertion.	<input type="checkbox"/> 28-day supply <input type="checkbox"/> _____	<input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> sodium chloride 0.9% 10 mL flush	Flush line with 10 mL, before and after inf. and p.r.n. line care.	<input type="checkbox"/> 28-day supply <input type="checkbox"/> _____	<input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> heparin 100 U/mL 5 mL PFS - For central line patients	Flush line with 5 mL, after final saline flush.	<input type="checkbox"/> 28-day supply <input type="checkbox"/> _____	<input type="checkbox"/> 11 <input type="checkbox"/> _____

**Pharmacy to dispense ancillary supplies as needed to establish IV and administer drug.**

<b>Prescriber and shipping information (please print)</b>	
Prescriber: _____	NPI: _____
Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Office <input type="checkbox"/> 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.