

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.

Multiple Sclerosis Injectable 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: _____ <input type="checkbox"/> New therapy <input type="checkbox"/> Continuing therapy Type: <input type="checkbox"/> Clinically isolated syndrome <input type="checkbox"/> Relapsing remitting <input type="checkbox"/> Secondary-progressive <input type="checkbox"/> Primary-progressive <input type="checkbox"/> Progressive-relapsing First clinical episode and MRI features consistent with MS? <input type="checkbox"/> No <input type="checkbox"/> Yes Date of last dose: _____ Date of first/next dose: _____	Previous failed therapies, discontinuation reasons and dates: <table border="1"> <thead> <tr> <th>Therapy</th> <th>Discontinuation reason</th> <th>Dates</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Therapy	Discontinuation reason	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	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Avonex <input type="checkbox"/> Pen <input type="checkbox"/> PFS	30 mcg	<input type="checkbox"/> Titration dose (for PFS): Inject 7.5 mcg IM on week 1, inject 15 mcg on week 2, inject 22.5 mcg on week 3 and inject 30 mcg on week 4 and weekly thereafter. <input type="checkbox"/> Inject 30 mcg IM weekly.	1 month	0 refills
<input type="checkbox"/> Betaseron <input type="checkbox"/> Extavia	0.3 mg	<input type="checkbox"/> Titration dose: Weeks 1–2: Inject 0.0625 mg SQ every other day. Weeks 3–4: Inject 0.125 mg SQ every other day. Weeks 5–6: Inject 0.1875 mg SQ every other day. Week 7+: Inject 0.25 mg SQ every other day. <input type="checkbox"/> Inject 0.25 mg SQ every other day.	1 month	0 refills
<input type="checkbox"/> Copaxone <input type="checkbox"/> glatiramer <input type="checkbox"/> Glatopa	<input type="checkbox"/> 20 mg <input type="checkbox"/> 40 mg	<input type="checkbox"/> Inject 20 mg SQ daily. <input type="checkbox"/> Inject 40 mg SQ three times weekly.	1 month	_____
<input type="checkbox"/> Lemtrada	Please complete the prescription form at www.lemtradarems.com/Docs/PDF/lemtrada_rems_prescription_ordering_form.pdf			
<input type="checkbox"/> Kesimpta	20 mg	<input type="checkbox"/> Titration dose: Inject 20 mg SQ at weeks 0, 1 and 2. <input type="checkbox"/> Inject 20 mg SQ at week 4, then every four weeks thereafter.	1 month	0 refills
<input type="checkbox"/> Ocrevus	300 mg	<input type="checkbox"/> Titration dose: Infuse 300 mg (10 mL) IV on days 1 and 15. <input type="checkbox"/> Infuse 600 mg (20 mL) IV every six months.	180 days	0 refills
<input type="checkbox"/> Plegridy (subcutaneous administration) <input type="checkbox"/> Pen <input type="checkbox"/> PFS	<input type="checkbox"/> Starter kit (SQ) <input type="checkbox"/> 125 mcg (SQ)	<input type="checkbox"/> Starter dose: Inject 63 mcg SQ on day 1, inject 94 mcg on day 15 and inject 125 mcg every 14 days thereafter. <input type="checkbox"/> Inject 125 mcg SQ every 14 days.	1 month	0 refills
<input type="checkbox"/> Plegridy (intramuscular administration) <input type="checkbox"/> PFS	<input type="checkbox"/> 125 mcg (IM)	<input type="checkbox"/> Starter dose: Inject 63 mcg IM on day 1, inject 94 mcg on day 15 and inject 125 mcg every 14 days thereafter. <input type="checkbox"/> Inject 125 mcg IM every 14 days.	1 month	0 refills
<input type="checkbox"/> Rebif <input type="checkbox"/> Pen <input type="checkbox"/> PFS	<input type="checkbox"/> Titration pack <input type="checkbox"/> 22 mcg <input type="checkbox"/> 44 mcg	<input type="checkbox"/> Titration dose: Weeks 1–2: Inject 8.8 mcg SQ three times weekly. Weeks 3–4: Inject 22 mcg SQ three times weekly. Week 5+: Inject 44 mcg SQ three times weekly. <input type="checkbox"/> Inject 22 mcg SQ three times weekly. <input type="checkbox"/> Inject 44 mcg SQ three times weekly.	1 month	_____
<input type="checkbox"/> Tysabri	Patient must be enrolled in TOUCH™ Prescribing Program. Please call 800-456-2255 or go to www.tysabri.com			

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.