

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.

Oral Oncology F–G 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: No Yes: _____

Clinical information

Need by date: _____ BSA: _____ m² Height: _____ Weight: _____ lb kg Date: _____
 ICD-10 code(s): _____ Diagnosis: _____ Diagnosis date: _____
 Renal dysfunction: No Yes Current SCr: _____ or current GFR: _____ mL/min Liver dysfunction: No Yes
 Abnormal lab values: _____ Concurrent medications: _____
 Confirmed predictive biomarker or genetic testing: No Yes If "Yes," list: _____

Previous therapy:	Discontinuation reason:	Dates:
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____

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"/> Fareston tablets (toremifene)	60 mg	<input type="checkbox"/> Take one tablet (60 mg) once daily.	_____	_____
<input type="checkbox"/> Farydak capsules (panobinostat)	<input type="checkbox"/> 10 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 20 mg	<input type="checkbox"/> Take one capsule once daily on days 1, 3, 5, 8, 10 and 12 of a 21-day cycle.	_____	_____
<input type="checkbox"/> Femara tablets (letrozole)	2.5 mg	<input type="checkbox"/> Take one tablet (2.5 mg) once daily.	_____	_____
<input type="checkbox"/> Gleevec tablets (imatinib)	<input type="checkbox"/> 100 mg <input type="checkbox"/> 400 mg	<input type="checkbox"/> Take one tablet (400 mg) daily with food.	_____	_____
<input type="checkbox"/> Gleostine capsules (lomustine)	<input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 40 mg <input type="checkbox"/> 100 mg	<input type="checkbox"/> Take ___ capsules (___ mg) once every 6 weeks.	_____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____	_____

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.