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.

Oral Oncology J–M 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: ______________m^2 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:
❒ ____________________	________________________________	____________
❒ ____________________	________________________________	____________
❒ ____________________	________________________________	____________

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
❒ Jakafi tablets (ruxolitinib)	❒ 5 mg ❒ 10 mg ❒ 15 mg ❒ 20 mg ❒ 25 mg	❒ Take one tablet twice daily.	______	____
❒ Kisqali 200 mg tablets (ribociclib) (Please see form "E–I" for letrozole.)	❒ 200 mg pack ❒ 400 mg pack ❒ 600 mg pack	❒ Take ______ mg once daily for 21 days followed by 7 days off.	______	____
❒ Kisqali 200 mg/Femara 2.5 mg Co-Pack (ribociclib/letrozole)	❒ 200 mg/2.5 mg pack ❒ 400 mg/2.5 mg pack ❒ 600 mg/2.5 mg pack	❒ Kisqali: Take ____ tablets (____ mg) once daily for 21 days followed by 7 days off. ❒ Femara: Take one tablet (2.5 mg) once daily throughout 28 days.	______	____
❒ Leukeran tablets (chlorambucil)	2 mg	________________________________	______	____
❒ Lorbrena tablets (lorlatinib)	❒ 25 mg ❒ 100 mg	❒ Take one tablet once daily.	______	____
❒ Mekinist tablets (trametinib) (Please see form "T" for Tafinlar, or write in the "Other" field below.)	❒ 0.5 mg ❒ 2 mg	❒ Take one tablet once daily on empty stomach.	______	____
❒ Mektovi tablets (binimetinib) (Please see form "A–D" for Braftovi.)	15 mg	❒ Take three tablets (45 mg) twice daily.	______	____
❒ Other: ________________	__________	________________________________	______	____
❒ 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.