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 R–S 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
❒ Retevmo capsules (selpercatinib)	❒ 40 mg ❒ 80 mg	❒ Take ____ capsules twice daily.	_____	____
❒ Rozlytrek capsules (entrectinib)	❒ 100 mg ❒ 200 mg	❒ Take _____ capsules once daily.	_____	____
❒ Rydapt capsules (midostaurin)	❒ 25 mg	❒ Take two capsules (50 mg) twice daily with food on days 8 through 21 (total 14 days of treatment).	_____	____
❒ Sprycel tablets (dasatinib)	❒ 20 mg ❒ 50 mg ❒ 70 mg ❒ 80 mg ❒ 100 mg ❒ 140 mg	❒ Take ____ tablet (____ mg) once daily.	_____	____
❒ Stivarga tablets (regorafenib)	40 mg	❒ Take four tablets (160 mg) daily on days 1 through 21 of each 28-day cycle after low-fat meal.	_____	____
❒ Sutent capsules (sunitinib)	❒ 12.5 mg ❒ 25 mg ❒ 37.5 mg ❒ 50 mg	❒ Take one capsule once daily for 4 weeks, followed by 2 weeks off.	_____	____
❒ 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.