Humana Pharmacy Solutions®

Place prescriber's office stamp or prescriber's letterhead (not to be handwritten or typed by the pharmacy) . Must include the prescriber's name, full address, DEA/NPI# and telephone number.

Patient's First Name	Patient's Last Name	Patient's DOB

Patient's Address	City, State, ZIP

Pharmacy's Name	Pharmacy's NCPDP	RX# of Script	Date of Service

Pharmacy's Address	City, State, ZIP	Phone	Fax

*****Complete the prescription information below*****

Prescriber's initials _____

Date Written

Patient's Name

Drug Name and Strength

Quantity Prescribed

Written Directions

Refills Authorized

******The section below is to be completed only by the prescriber, or for LTC facilities, by the attending physician******

I, _____ (*prescriber's printed name)* do hereby state that I have reviewed the above information and the information I provided is true and correct, to the best of my knowledge.

Prescriber's Signature	*Date Signed*	*Prescriber's NPI/ (DEA If applicable)*

All prescriber statements must be properly submitted on this Humana issued Uniformed Prescriber Statement form by the applicable due dates communicated in the audit letter (See Page 1 for your pharmacy's due date). Humana reserves the right to revise the form at any time at its sole discretion. Prescriber statements not on this Humana issued Uniform Prescriber Statement form will not be accepted. Notwithstanding the foregoing, Humana will review any additional forms of mitigating documentation if required by state laws governing audits of pharmacies, unless the state law is preempted or otherwise inapplicable.

For more audit-related documents, visit **Humana.com/provider/pharmacy-resources/manuals-forms.**

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