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 C–E 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
☐ Cabometyx tablets (cabozantinib)	☐ 20 mg ☐ 40 mg ☐ 60 mg	☐ Take one tablet once daily on an empty stomach.	_______	_____
☐ Cotellic tablets (cobimetinib) (Please see form "U–X" for Zelboraf, or write in the "Other" field below.)	20 mg	☐ Take three tablets (60 mg) once daily for 21 days. Repeat this cycle every 28 days.	_______	_____
☐ cyclophosphamide capsules	☐ 25 mg ☐ 50 mg	____	_______	_____
☐ Daurismo tablets (glasdegib)	☐ 25 mg ☐ 100 mg	☐ Take one tablet once daily on days 1 to 28.	_______	_____
☐ Emcyt capsules (estramustine)	140 mg	____	_______	_____
☐ Erivedge capsules (vismodegib)	150 mg	☐ Take one capsule (150mg) once daily.	_______	_____
☐ Erleada tablets (apalutamide)	60 mg	☐ Take four tablets (240mg) once daily.	_______	_____
☐ erlotinib tablets	☐ 25 mg ☐ 100 mg ☐ 150 mg	☐ Take one tablet once daily on an empty stomach.	_______	_____
☐ etoposide capsules	50 mg	____	_______	_____
☐ 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.