Humana Pharmacy

Fax: 877-405-7940
Phone: 800-486-2668

Humana Specialty Pharmacy®

Monday – Friday, 8 a.m. – 11 p.m., and
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.

Lysosomal Storage Disorders 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: ____

Height: ______ Weight: _____ ❒ lb. ❒ kg Date: ________

Clinical information

Diagnosis ICD-10 code ❒ Fabry disease E7521 ❒ Gaucher disease E7522 ❒ Hunter syndrome E76.1 ❒ Hurler syndrome E76.01
❒ Lysosomal alpha-1 deficiency E74.02 ❒ Mucopolysaccharidosis VI (MPS VI) E76.29 ❒ Pompe disease E74.02
❒ Sanfilippo syndrome (mucopolysaccharidosis III) E76.3 ❒ Scheie syndrome E76.03 ❒ Other: ____

Additional PA ❒ New therapy ❒ Continuing therapy ❒ Investigational **First dose?** ❒ Yes ❒ No **Expected date of first/next infusion:** _________________
Venous access: ❒ Peripheral ❒ Port ❒ PICC ❒ CL: Type ___________ **Infuse via** ❒ Pump ❒ Gravity as tolerated by patient ❒ Other: ____________

❒ Skilled nursing visit to establish venous access, provide patient education related to therapy and disease state, administer medication as prescribed and assess general status and response to therapy. Visit frequency based on prescribed dosage orders.
❒ Pharmacy to dispense ancillary supplies as needed to establish IV and administer drug.

Prescription information

Note: Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Medication	Dose	Directions	Quantity	Refills
❒ Aldurazyme	❒ 2.9 mg vial	Dose: ________________ mg units IV Volume to infuse: ______________________ Frequency: ____________________________ Rate (mL): ____________________________ ❒ Titrate per manufacturer guidelines	❒ 28-day supply	❒ ______
❒ Cerezyme	❒ 400-unit vial			
❒ Elaprase	❒ 6 mg vial			
❒ Fabrazyme	❒ 5 mg vial ❒ 35 mg vial			
❒ Lumizyme	❒ 50 mg vial			
❒ VPRIV	❒ 200-unit vial ❒ 400-unit vial			
❒ Cerdelga	❒ 84 mg capsule	Take one capsule _____ time(s) per day.	❒ 28-day supply	❒ ______
❒ Sterile water	❒ 10 mL	UAD for reconstitution of enzyme.	❒ 28-day supply	❒ ______
❒ Sodium chloride 0.9%	❒ 100 mL ❒ 200 mL ❒ 500 mL	Use to further dilute reconstituted enzyme.	❒ 28-day supply	❒ ______
❒ Normal saline flush	❒ 10 mL PFS	Flush line with 5–10 mL before and after IV drug and P.R.N. line care.	❒ 28-day supply	❒ ______
❒ heparin 100 units flush	❒ 5 mL PFS	Flush line with 3–5 mL post infusion and P.R.N. line care.	❒ 28-day supply	❒ ______
❒ lidocaine/prilocaine cream 2.5%-2.5%	❒ 30 gm	Apply topically to needle insertion site 30–60 minutes prior to needle insertion as directed.	❒ 28-day supply	❒ ______
❒ Pretreatment	❒ acetaminophen 325 mg P.O.	Take 1–2 tablets P.O. 30–60 minutes prior to infusion and every 4–6 hours P.R.N. Maximum four doses per day.	❒ 10 tablets	❒ ______
	❒ diphenhydramine 25 mg capsules	Take 1–2 capsules P.O. 30–60 minutes prior to infusion and every 4–6 hours P.R.N. Maximum four doses per day.	❒ 10 capsules	❒ ______
❒ Adverse reaction medications: To be available at all times	❒ EpiPen 0.3 mg auto-injector ❒ Substitution allowed	UAD IM P.R.N. severe anaphylactic reaction times one dose; may repeat one time. Dispense 0.3 mg for patient weighing greater than or equal to 30 kg.	❒ 2-pack	❒ ______
	❒ diphenhydramine 25–50 mg capsules	Administered by mouth P.R.N. allergic reactions/anaphylaxis	❒ 10 capsules	❒ ______

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.