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.

Ophthalmology 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

ICD-10 code: ____________________________

If applicable, please provide each previous therapy and its dates:

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	Dose	Route	Directions	Quantity	Refills
❒ Beovu	❒ 6 mg/0.05 mL SDV	❒ OD ❒ OS ❒ OU		_______	______
❒ Eylea	❒ 2 mg/0.05 mL SDV ❒ 2 mg/0.05 mL PFS	❒ OD ❒ OS ❒ OU		_______	______
❒ Lucentis	❒ 0.3 mg/0.05 mL SDV ❒ 0.5 mg/0.05 mL SDV ❒ 0.3 mg/0.05 mL PFS ❒ 0.5 mg/0.05 mL PFS	❒ OD ❒ OS ❒ OU		_______	______
❒ Ozurdex	❒ 0.7 mg implant	❒ OD ❒ OS ❒ OU		_______	______
❒ Triesence	❒ 40 mg/mL SDV	❒ OD ❒ OS ❒ OU		_______	______
❒ Visudyne	❒ 15 mg SDV	IV		_______	______
❒ Iluvien	❒ 0.19 mg implant	❒ OD ❒ OS ❒ OU		_______	______
❒ Other		❒ OD ❒ OS ❒ OU		_______	______

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.