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.

Self-administered Pediatric Rheumatology Prescription Form

Patient information

Patient: _____ ❒ Female ❒ Male DOB: _____ Height: _____ Weight: _____ ❒ lb ❒ kg Date: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Home phone #: _____ Cell phone #: _____ Caregiver: _____ Caregiver phone #: _____

Other medical conditions: _____ Allergies: ❒ No ❒ Yes: _____

Insurance plan: _____ Plan ID #: _____ BIN: _____ PCN: _____ Group #: _____

*Please send a copy of the patient's prescription insurance card if available.

Clinical information

Concurrent medications: _____ Is the patient taking methotrexate? ❒ No ❒ Yes

Prior medications: ❒ acetaminophen, ibuprofen or naproxen sodium ❒ Azulfidine ❒ calcipotriene ❒ Celebrex ❒ corticosteroids ❒ Enbrel ❒ Humira ❒ Indocin ❒ Kevzara ❒ methotrexate *Justification for prior medications:* _____

Date of negative TB test: _____ Has a physician ruled out hepatitis B? ❒ Yes ❒ No *If "No," has a physician initiated treatment?* _____

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
❒ Actemra	❒ 162 mg/0.9 mL PFS ❒ 162 mg/0.9 mL pen	❒ Inject 162 mg SQ every week ❒ Inject 162 mg SQ every two weeks ❒ Inject 162 mg SQ every three weeks ❒ _____	❒ 1 PFS or 1 pen ❒ 2 PFS or 2 pens ❒ 28-day supply ❒ _____	_____
❒ Enbrel	❒ 50 mg/mL PFS ❒ 50 mg/mL SureClick ❒ 50 mg/mL Mini cartridge ❒ 25 mg/0.5 mL PFS ❒ 25 mg vial	❒ Inject 50 mg SQ once a week ❒ Inject 25 mg SQ once a week ❒ Inject ____ mg SQ once a week ❒ _____	❒ 28-day supply ❒ _____	_____
❒ Humira	❒ 10 mg/0.1 mL PFS ❒ 20 mg/0.2 ml PFS ❒ 40 mg/0.4 mL pen ❒ 40 mg/0.4 mL PFS ❒ 40 mg/0.8 mL pen ❒ 40 mg/0.8 mL PFS	❒ Inject 10 mg SQ every other week ❒ Inject 20 mg SQ every other week ❒ Inject 40 mg SQ every other week ❒ Inject 40 mg SQ once weekly ❒ _____	❒ 28-day supply ❒ _____	_____
❒ Orencia	❒ 50 mg/0.4 mL PFS ❒ 87.5 mg/0.7mL PFS ❒ 125 mg/mL PFS ❒ 125 mg/mL ClickJet	❒ Inject 50 mg SQ once a week ❒ Inject 87.5 mg SQ once a week ❒ Inject 125 mg SQ once a week ❒ _____	❒ 28-day supply ❒ _____	_____
❒ Xeljanz	❒ 1 mg/mL oral solution ❒ 5 mg tablet	❒ Take 3.2 mL by mouth twice daily ❒ Take 4 mL by mouth twice daily ❒ Take 5 mL by mouth twice daily ❒ Take one tablet by mouth twice daily	❒ 28-day supply ❒ 60 tablets ❒ _____	_____
❒ 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.