



**Patient Information**

Member ID  -  Date of Birth  /  /  Gender  Male  Female

First Name  Last Name  M.I.

Street Number  Street Name  Apt/Suite #

City  State  ZIP Code  -

Phone Number  -  -  Allergies:  No Known  Aspirin  Codeine  Penicillin  
 Peanuts  Sulfa  Other \_\_\_\_\_

**Prescriber Information**

Prescriber First Name  Prescriber Last Name  M.I.

DEA Number  NPI Number

Street Number  Street Name  Suite #

City  State  ZIP Code  -

Phone Number  -  -  Fax Number  -  -

**Prescription Information**

**Rx** Must be **completed, signed** and **faxed** from provider's office. This is not valid for CII medications. We will dispense a 90-day supply unless the quantity is otherwise noted or the medication is a controlled substance. In order to require that a brand-name product be dispensed, the prescriber must write 'brand medically necessary.'

	Drug Name and Strength	Directions	Quantity <small>(Alpha &amp; Numeric required for controlled substances)</small>	# of Refills
1.				
2.				
3.				

**Prescriber Signature** (required) \_\_\_\_\_ **Today's Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Supervising Prescriber Signature** (if applicable) \_\_\_\_\_ **Today's Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Supervising Prescriber DEA Number** \_\_\_\_\_ **Supervising Prescriber NPI Number:** \_\_\_\_\_

Please fax completed form with secure cover sheet to Humana Pharmacy at **1-800-379-7617**

-or-

Send this prescription electronically (eRx) by selecting "Humana Pharmacy Mail Delivery" from the list of pharmacies on your e-prescribing tool. All eRx from your office will be routed through SureScripts directly to Humana Pharmacy.