CenterWell Specialty Pharmacy

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

CenterWell 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.

Oral Oncology N–P 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
❒ Nexavar tablets (sorafenib)	200 mg	❒ Take two tablets (400 mg) twice daily on empty stomach.	______	____
❒ Nubeqa tablets (darolutamide)	300 mg	❒ Take two tablets (600 mg) twice daily with food.	______	____
❒ Odomzo capsules (sonidegib)	200 mg	❒ Take one capsule (200 mg) once daily on empty stomach.	______	____
❒ Onureg tablets (oral azacitidine)	❒ 200 mg ❒ 300 mg	❒ Take 1 tablet (300 mg) once daily on days 1 through 14 of a 28-day cycle.	______	____
❒ Piqray tablets (alpelisib)	❒ 200 mg pack ❒ 250 mg pack ❒ 300 mg pack	❒ Take _____ mg once daily with food.	______	____
❒ Other: ___________________	__________	____	______	____
❒ 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, fax language. Noncompliance with state-specific requirements could result in outreach to the prescriber.