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.

Oncology REMS 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: _____

Height: _____ Weight: _____ ❒ lb ❒ kg Date: _____

Clinical information

Need by date: _____ BSA: _____ m^2

ICD-10 code(s): _____ Diagnosis: _____ Diagnosis date: _____

Concurrent medications: _____

Renal dysfunction: ❒ No ❒ Yes Current SCr: _____ or current GFR: _____mL/min

Liver dysfunction: ❒ No ❒ Yes Abnormal lab values: _____

REMS information

Authorization #: _____
Date obtained: _____

Patient type:

❒ Adult female: Childbearing potential
❒ Adult female: **No** childbearing potential
❒ Adult male
❒ Child female: Childbearing potential
❒ Child female: **No** childbearing potential
❒ Child male

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
❒ Pomalyst capsules (pomalidomide)	❒ 1 mg ❒ 2 mg ❒ 3 mg ❒ 4 mg	❒ Take one capsule daily for 21 days followed by 7 days off. ❒ Other: _____	_____	N/A
❒ Revlimid capsules (lenalidomide)	❒ 2.5 mg ❒ 5 mg ❒ 10 mg	❒ Take one capsule daily. ❒ Take one capsule daily for 21 days followed by 7 days off. ❒ Other: _____	_____	N/A
	❒ 15 mg ❒ 20 mg ❒ 25 mg	❒ Take one capsule daily for 21 days followed by 7 days off. ❒ Other: _____	_____	
❒ Thalomid capsules (thalidomide)	❒50 mg ❒100 mg ❒150 mg ❒200 mg	❒ Take one capsule daily. ❒ Other: _____	❒ 28 ❒ 56 ❒ 84 ❒ _____	N/A
❒ 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 and fax language. Noncompliance with state-specific requirements could result in outreach to the prescriber.