

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.

Dermatology A–O Prescription Form

Patient information

Patient: _____ Female Male DOB: _____ Insurance plan: _____ Plan ID #: _____
 Address: _____ City: _____ State: _____ ZIP code: _____
 Home phone #: _____ Cell phone #: _____ Caregiver: _____ Caregiver phone #: _____

Clinical information

Height: _____ Weight: _____ lb kg Date: _____ ICD-10 code: _____ Diagnosis: _____ Diagnosis date: _____
 BSA: _____ m² TB test: No Yes Negative test date: _____ HBV: No Yes If yes, currently treated? No Yes
 % BSA affected: _____ Affected areas: Hands Feet Head Neck Other: _____
 Concurrent medications: _____ Other medical conditions: _____ Allergies: No Yes: _____
 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	Directions	Quantity	Refills	
<input type="checkbox"/> Adbry	Initial Dose: <input type="checkbox"/> Inject 600 mg SQ on day 1, followed by 300mg every other week Maintenance Dose: <input type="checkbox"/> Inject 300mg SQ every other week <input type="checkbox"/> Inject 300mg SQ every four weeks	<input type="checkbox"/> 1 kit <input type="checkbox"/> 1 month	0 _____	
<input type="checkbox"/> Cibinqo <input type="checkbox"/> 50mg tablets <input type="checkbox"/> 100mg tablets <input type="checkbox"/> 200mg tablets	<input type="checkbox"/> Take 50mg PO once daily <input type="checkbox"/> Take 100mg PO once daily <input type="checkbox"/> Take 200mg PO once daily <input type="checkbox"/> _____	<input type="checkbox"/> 1 month	_____	
<input type="checkbox"/> Cimzia (certolizumab) <input type="checkbox"/> PFS <input type="checkbox"/> Vials	<input type="checkbox"/> Inject 400 mg SQ at weeks 0, 2 and 4 <input type="checkbox"/> Inject 200 mg SQ every 2 weeks <input type="checkbox"/> Inject 400 mg SQ every 2 weeks <input type="checkbox"/> Inject 400 mg SQ every 4 weeks	<input type="checkbox"/> 1 starter kit <input type="checkbox"/> 1 month	0 _____	
<input type="checkbox"/> Cosentyx (secukinumab) <input type="checkbox"/> Pen <input type="checkbox"/> PFS	<input type="checkbox"/> Inject 150 mg SQ once weekly at weeks 0, 1, 2 and 3 <input type="checkbox"/> Inject 300 mg SQ once weekly at weeks 0, 1, 2 and 3 <input type="checkbox"/> Inject 150 mg SQ on week 4 and every 4 weeks thereafter <input type="checkbox"/> Inject 300 mg SQ on week 4 and every 4 weeks thereafter	<input type="checkbox"/> 1 month <input type="checkbox"/> 1 month	0 _____	
<input type="checkbox"/> Dupixent (dupilumab) <input type="checkbox"/> Pen <input type="checkbox"/> PFS	<input type="checkbox"/> Inject 600 mg SQ on day 1, followed by 300 mg SQ on day 15 and every 2 weeks thereafter <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 month	0	
<input type="checkbox"/> Enbrel (etanercept) <input type="checkbox"/> Pen <input type="checkbox"/> PFS <input type="checkbox"/> Mini cartridge <input type="checkbox"/> Vials	<input type="checkbox"/> Inject 50 mg SQ twice a week (72–96 hours apart) for 3 months <input type="checkbox"/> Other: _____ <input type="checkbox"/> Inject 50 mg SQ every week <input type="checkbox"/> Inject _____ mg (0.8 mg/kg x _____ kg) SQ every week (pediatric ≤ 63 kg) <input type="checkbox"/> Other: _____	<input type="checkbox"/> 3 months <input type="checkbox"/> 1 month	0 _____	
<input type="checkbox"/> Humira (adalimumab)	Initial dose <input type="checkbox"/> Psoriasis 80 mg/40 mg citrate-free pens starter pack (3 pens) <input type="checkbox"/> Psoriasis 40 mg/0.8 mL pen starter pack (4 pens) <input type="checkbox"/> Hidradenitis suppurativa (HS) 80 mg/0.8 mL citrate-free pen starter kit (3 pens) <input type="checkbox"/> HS 40 mg/0.8 mL starter pack (6 pens) Maintenance dose <input type="checkbox"/> 40 mg/0.8 mL pen <input type="checkbox"/> 40 mg/0.8 mL PFS <input type="checkbox"/> 40 mg/0.4 mL pen <input type="checkbox"/> 40 mg/0.4 mL PFS <input type="checkbox"/> 80 mg/0.8 mL pen	<input type="checkbox"/> Psoriasis: Inject 80 mg SQ on day 1, then 40 mg on day 8, then 40 mg every 2 weeks thereafter <input type="checkbox"/> Hidradenitis suppurativa: Inject 160 mg SQ on day 1, then 80 mg on day 15 <input type="checkbox"/> Psoriasis: Inject 40 mg SQ every 2 weeks <input type="checkbox"/> HS: Inject 40 mg SQ on day 29 and every week thereafter <input type="checkbox"/> HS: Inject 80 mg SQ every other week thereafter <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 starter kit <input type="checkbox"/> 1 month	0 _____
<input type="checkbox"/> Ilumya (tildrakizumab)	<input type="checkbox"/> Inject 100 mg at week 0 <input type="checkbox"/> Inject 100 mg at week 4 and every 12 weeks thereafter	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 month	0 _____	
<input type="checkbox"/> Opzelura 1.5% Cream (60 g tube)	<input type="checkbox"/> _____	<input type="checkbox"/> _____	_____	
<input type="checkbox"/> Orencia (abatacept) <input type="checkbox"/> Vials <input type="checkbox"/> PFS <input type="checkbox"/> Pen	<input type="checkbox"/> Infuse _____ mg at week 0 and 2 <input type="checkbox"/> Infuse _____ mg at week 4 and every 4 weeks thereafter	<input type="checkbox"/> 1 month	_____	
<input type="checkbox"/> Otezla (apremilast) <input type="checkbox"/> Tablets	<input type="checkbox"/> Inject 125 mg SQ once weekly <input type="checkbox"/> Other: _____ <input type="checkbox"/> Take 30 mg by mouth twice daily	<input type="checkbox"/> 1 month <input type="checkbox"/> 1 month	_____	

Prescriber and shipping information (please print)

Prescriber: _____ NPI: _____
 Ship to: Patient Office Other: _____ Office phone number: _____ Office fax number: _____
 Office address: _____ City: _____ State: _____ ZIP code: _____
 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.