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.

Self-administered Rheumatology Prescription Form P-Z

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

ICD-10 code: _____ Diagnosis: _____ Diagnosis date: _____

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:* _____

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

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
❒ Rinvoq	15 mg ER tablet	❒ Take 15 mg PO once daily with or without food	❒ 30 tablets	_____
❒ Simponi	❒ 50 mg/0.5 mL PFS ❒ 50 mg/0.5 mL SmartJect	❒ Inject 50 mg SQ once monthly	❒ One device	_____
❒ Skyrizi	❒ 150mg/ml PFS ❒ 150mg/ml Pen	Initial: ❒ Inject 150 mg SQ at week 0	❒ 28-day supply	0
		Maintenance: ❒ Inject 150 mg SQ at week 4 then every 12 weeks	❒ 84-day supply	_____
❒ Stelara	❒ 45mg/0.5ml PFS ❒ 90mg/ml PFS	Initial: ❒ Inject 45 mg SQ at week 0 ❒ Inject 90 mg SQ at week 0	❒ 28-day supply	0
		Maintenance: ❒ Inject 45mg SQ at week 4 then every 12 weeks ❒ Inject 90mg SQ at week 4 then every 12 weeks	❒ 84-day supply	_____
❒ Taltz	❒ 80mg/ml PFS ❒ 80mg/ml Autoinjector Pen	Initial: ❒ Inject 160mg SQ at week 0	❒ 28-day supply	0
		Maintenance: ❒ Inject 80mg SQ every 4 weeks	❒ 28-day supply	_____
❒ Tremfya	❒ 100mg/ml PFS ❒ 100mg/ml One-Press Injector	Initial: ❒ Inject 100mg SQ at week 0	❒ 28-day supply ❒ 56-day supply	0
		Maintenance: ❒ Inject 100mg SQ at week 4 then every 8 weeks		_____
❒ Xeljanz	❒ 5 mg tablet ❒ 11 mg XR tablet	❒ Take 5 mg PO twice daily ❒ Take 11 mg XR PO once daily	❒ 60 tablets ❒ 30 tablets	_____
❒_____	_____	_____	_____	_____
❒_____	_____	_____	_____	_____
❒_____	_____	_____	_____	_____

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.