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 H–J 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
❒ Hycamtin capsules (topotecan)	❒ 0.25 mg ❒ 1 mg	_____	_____	_____
❒ Ibrance tablets (palbociclib) (Please provide a prescription for concomitant therapy.)	❒ 75 mg ❒ 100 mg ❒ 125 mg	❒ Take one tablet once daily for 21 days followed by 7 days off.	_____	_____
❒ Idhifa tablets (enasidenib)	❒ 50 mg ❒ 100 mg	❒ Take one tablet once daily.	_____	_____
❒ Inlyta tablets (axitinib)	❒ 1 mg ❒ 5 mg	❒ Take one tablet twice daily with water.	_____	_____
❒ Inrebic capsules (fedratinib)	100 mg	❒ Take four capsules (400 mg) once daily.	_____	_____
❒ Jakafi tablets (ruxolitinib)	❒ 5 mg ❒ 10 mg ❒ 15 mg ❒ 20 mg ❒ 25 mg	❒ Take one tablet twice daily.	_____	_____
❒ 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.