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 Y–Z 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
❒ Yonsa tablets (abiraterone) (To prescribe methylprednisolone, please write in the "Other" field below.)	125 mg	❒ Take four tablets (500 mg) once daily.	_____	____
❒ Zelboraf tablets (vemurafenib) (Please see form "C–E" for Cotellic, or write in the "Other" field below.)	240 mg	❒ Take four tablets (960 mg) twice daily.	_____	____
❒ Zolinza capsules (vorinostat)	100 mg	❒ Take four capsules (400 mg) once daily with food.	_____	____
❒ Zykadia (ceritinib)	❒ 150 mg **capsules** ❒ 150 mg **tablets**	❒ Take three **capsules** (450 mg) once daily with food. ❒ Take three **tablets** (450 mg) once daily with food.	_____	____
❒ Zytiga tablets (abiraterone) (To prescribe prednisone, please write in the "Other" field below.)	❒ 250 mg ❒ 500 mg	❒ Take 1,000 mg once daily on an empty stomach. ❒ Take 250 mg once daily after a low-fat breakfast.	_____	____
❒ 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.