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.

Dermatology P-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 #: _____

Clinical information

Height: _____ Weight: _____ ❒ lb ❒ kg Date: _____ ICD-10 code: _____ Diagnosis: _____ Diagnosis date: _____

BSA: _____ m^2 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
❒ Rinvoq	❒ Take one tablet (15mg) PO once daily ❒ Take one tablet (30mg) PO once daily	❒ 1 month	___
❒ Siliq PFS (brodalumab)	❒ Inject 210 mg SQ on weeks 0, 1 and 2, followed by 210 mg SQ every 2 weeks thereafter.	❒ 1 month	0
	❒ Inject 210 mg SQ every 2 weeks.	❒ 1 month ❒ _____	___
❒ Simponi (golimumab) ❒ Pen ❒ PFS	❒ Inject 50 mg SQ once a month.	❒ 1 month ❒ _____	___
❒ Simponi Aria (golimumab)	❒ Infuse _____ mg (2mg/kg x _____ kg) over 30 minutes at week 0.	❒ 1 month	0
	❒ Infuse _____ mg (2mg/kg x _____ kg) over 30 minutes at week 4 and every 8 weeks thereafter.	❒ _____	___
❒ Skyrizi (risankizumab) ❒ Pen ❒ PFS	❒ Inject 150 mg SQ at week 0.	❒ 28 days	0
	❒ Inject 150 mg SQ at week 4 and inject 150 mg SQ every 12 weeks thereafter.	❒ 84 days	___
❒ Sotyktu	❒ Take one tablet (6mg) PO once daily	❒ 1 month	___
❒ Stelara (ustekinumab) ❒ PFS ❒ Vials (pediatric dose)	❒ Inject 45 mg SQ on day 1. ❒ Inject 90 mg SQ on day 1 (> 100 kg). ❒ Inject _____ m (0.75 mg/kg x _____ kg) SQ on day 1 (pediatric < 60kg).	❒ 1 month	0
	❒ Inject 45 mg SQ on day 29 and every 12 weeks thereafter. ❒ Inject 90 mg SQ on day 29 and every 12 weeks thereafter (> 100 kg). ❒ Inject _____ mg (0.75 mg/kg x _____ kg) SQ on day 29 and every 12 weeks thereafter (pediatric < 60 kg).	❒ 84 days ❒ _____	___
❒ Taltz (ixekizumab) ❒ Pen ❒ PFS	❒ Weeks 0–2: Inject 160mg SQ at week 0, then inject 80 mg SQ at week 2. ❒ Weeks 4–10: Inject 80 mg SQ at week 4 and every 2 weeks thereafter, through week 10.	❒ 1 month	1
	❒ Week 12 onward: Inject 80 mg SQ at week 12 and every 4 weeks thereafter.	❒ 1 month ❒ _____	___
❒ Tremfya PFS (guselkumab) ❒ One-Press Injector ❒ PFS	❒ Inject 100 mg SQ at week 0.	❒ 28 days	0
	❒ Inject 100 mg SQ at week 4 and every 8 weeks thereafter.	❒ 56 days ❒ _____	___

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.