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.

Oncology A–B 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
❒ Afinitor tablets (everolimus)	❒ 2.5 mg ❒ 5 mg ❒ 7.5 mg ❒ 10 mg	❒ Take one tablet once daily.	_______	_____
❒ Afinitor Disperz (everolimus)	❒ 2 mg ❒ 3 mg ❒ 5 mg	❒ Dissolve ____ tablet(s) in water and drink once daily.	_______	_____
❒ Alecensa capsules (alectinib)	150 mg	❒ Take four capsules (600 mg) twice a day with food.	_______	_____
❒ Alkeran tablets (melphalan)	2 mg	____	_______	_____
❒ Arimidex tablets (anastrozole)	1 mg	❒ Take one tablet (1 mg) once daily.	_______	_____
❒ Aromasin tablets (exemestane)	25 mg	❒ Take one tablet (25 mg) once daily after a meal.	_______	_____
❒ Bosulif tablets (bosutinib)	❒ 100 mg ❒ 400 mg ❒ 500 mg	❒ Take one tablet once daily with food.	_______	_____
❒ Braftovi capsules (encorafenib) (Please see form “J–M” for Mektovi)	75 mg	❒ Take six capsules (450 mg) once daily (for melanoma) ❒ Take four capsules (300 mg) once daily (for CRC)	_______	_____
❒ 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.