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.

Inflammatory Bowel Disease Prescription Form

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(s): _____ Diagnosis: _____ Diagnosis date: _____ ❒ New therapy ❒ Continuing therapy ❒ Investigational therapy

Concurrent medications: _____

If applicable, please provide each previous therapy and its dates:

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	Dose	Directions	Quantity	Refills
❒ Cimzia	Initial dose: ❒ Starter kit (200 mg PFS) ❒ 200 mg lyo. vial	Inject 400 mg SQ at weeks 0, 2 and 4	1 month	0
	Maintenance dose: ❒ 200 mg/mL PFS ❒ 200 mg lyo. vial	❒ Inject 400 mg SQ every four weeks ❒ _____	❒ 1 month ❒ _____	_____
❒ Humira	Initial Dose: ❒ Crohn's Disease and Ulcerative Colitis 40 mg/0.8mL starter pack ❒ Crohn's Disease and Ulcerative Colitis 80 mg/0.8mL starter pack (Citrate Free)	❒ Inject 160 mg SQ on day 1, and then, inject 80 mg SQ on day 15. ❒ Inject 80 mg SQ on days 1 and 2, and then, inject 80 mg SQ on day 15.	1 kit	0
	Maintenance Dose: ❒ 40 mg/0.8mL pen ❒ 40 mg/0.8mL PFS ❒ 40 mg/0.4mL pen (Citrate Free) ❒ 40 mg/0.4mL PFS (Citrate Free)	❒ Starting on day 29, inject 40 mg SQ every other week. ❒ _____	❒ 1 month ❒ _____	_____
❒ Simponi	Initial dose: ❒ 100 mg/mL PFS ❒ 100 mg/mL SmartJect	Inject 200 mg SQ at week 0, and then inject 100 mg SQ at week 2	1 month	0
	Maintenance dose: ❒ 100 mg/mL PFS ❒ 100 mg/mL SmartJect	❒ Inject 100 mg SQ every four weeks ❒ _____	❒ 1 month ❒ _____	_____
❒ Stelara	Initial dose: ❒ 130 mg/26 mL IV SDV	❒ Administer 260 mg IV at week 0 (weight 55 kg or less) ❒ Administer 390 mg IV at week 0 (weight 55–85 kg) ❒ Administer 520 mg IV at week 0 (weight > 85 kg)	❒ 2 vials ❒ 3 vials ❒ 4 vials	0
	Maintenance dose: ❒ 90 mg/mL PFS	❒ Inject 90 mg SQ eight weeks after initial IV induction, and then inject 90 mg SC every eight weeks thereafter	❒ 1 syringe ❒ _____	_____
❒ Xeljanz	Initial Dose: ❒ 10 mg tablet ❒ 22 mg XR tablet	❒ Take 10 mg PO twice daily. ❒ Take 22 mg XR PO once daily.	❒ 8 weeks ❒ _____	0
	Maintenance Dose: ❒ 5 mg tablet ❒ 11 mg XR tablet	❒ Take 5 mg PO twice daily. ❒ Take 11 mg XR PO once daily.	❒ 1 month ❒ _____	_____

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.