Fax: 800-345-8534
Phone: 855-264-0104

CenterWell Specialty Pharmacy

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Monday – Friday: 8 a.m. – 11 p.m., and
Saturday: 8 a.m. – 6:30 p.m., Eastern time

General Infusion Prescription Form

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

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: Please Include History and Physical (H&P) and latest visit note including infection history/treatment for past 6 months

ICD-10 code: _____ Diagnosis date: _____Concurrent therapies:
_____
Previous therapies: _____Discontinuation reason: _____ Date:
_____
Height: _____ Weight: _____ ❒ lb ❒ kg Date: _____

First dose: ❒ No ❒ Yes Expected date of first/next infusion: _____ Site of care: ❒ Home ❒ MDO ❒ Clinic:
_____
Venous access (for applicable therapies): ❒ PIV ❒ PICC ❒ Port ❒ Central line, type: _____
Infusion method: ❒ Gravity ❒ Pump

Prescription information

Note: Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Medications/supplies	Directions	Quantity	Refills
_____ Dose: _____	_____ _____	❒ 28-day supply ❒ Other: _____	❒ 11 ❒ _____
_____ Dose: _____	_____ _____	❒ 28-day supply ❒ Other: _____	❒ 11 ❒ _____
❒ Skilled nursing visit to establish venous access, provide patient education related to therapy and disease state, administer medication as prescribed, and assess general status and response to therapy. Frequency based on prescription dose orders.			
Pretreatment: ❒ acetaminophen ❒ 325 mg tablet ❒ 500 mg tablet ❒ diphenhydramine ❒ 25 mg capsule ❒ 50 mg tablet	❒ Take _____mg p.o. 30–60 min. prior to inf. and q4–6 p.r.n. Max. four doses in 24 hr. ❒_____	❒ 10 capsules ❒ 10 tablets ❒_____	❒ 11 ❒ _____
Anaphylaxis Kit (Patient's home):	❒ Epinephrine 0.3 mg auto-injector — ❒ Inject IM p.r.n. anaphylaxis — ❒ 2-pack		❒ 0 ❒ _____
	❒ Epinephrine 0.15 mg auto-injector (patients 15–30 kg) — ❒ Inject IM p.r.n. anaphylaxis — ❒ 2-pack		
	❒ Diphenhydramine 25 mg capsules — ❒ Take 25–50 mg PO p.r.n. anaphylaxis — ❒ 10 capsules		
	❒ Diphenhydramine 50 mg/mL injection — ❒ Inject slow IV push p.r.n anaphylaxis — ❒ 1 vial		
❒ lidocaine 2.5% and prilocaine 2.5% cream	Apply topically to needle insertion site, 30–60 min. prior to insertion.	❒ 28-day supply ❒ _____	❒ 11 ❒ _____
❒ lidocaine 2.5% and prilocaine 2.5% cream	Apply topically to needle insertion site, 30–60 min. prior to insertion.	❒ 28-day supply ❒ _____	❒ 11 ❒ _____
❒ sodium chloride 0.9% 10 mL flush	Flush line with 10 mL, before and after inf. and p.r.n. line care.	❒ 28-day supply ❒ _____	❒ 11 ❒ _____
❒ heparin 100 U/mL 5 mL PFS - For central line patients	Flush line with 5 mL, after final saline flush.	❒ 28-day supply ❒ _____	❒ 11 ❒ _____

Pharmacy to dispense ancillary supplies as needed to establish IV and administer drug.

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.