CenterWell Pharmacy

Fax: 877-405-7940
Phone: 800-486-2668

CenterWell Specialty Pharmacy™

Monday – Friday: 8 a.m. – 11 p.m. Eastern 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 to the number above.

Inflammatory Bowel Disease Pediatric 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 patients 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
❒ Humira	<u>Initial Dose Crohn's Disease:</u> ❒ Crohns Pediatric 80mg/0.8ml Disease Starter Pack (3 syringes) CF ($\geq 40kg$) ❒ Crohns Pediatric Disease Starter Pack (1-40mg/0.4ml syringe,1-80mg/0.8ml syringe)(2 syringes) CF (17 to 39 kg)	<u>Initial Dose Crohn's Disease:</u> ❒ Inject 160mg SQ on day 1, then 80mg SQ on day 15 ❒ Inject 80mg SQ on day 1 & 2 then 80mg SQ on day 15 ❒ Inject 80mg SQ on day 1, then 40mg SQ on day 15	Quantity Sufficient for Initial Dose	0
	<u>Initial Dose Ulcerative Colitis:</u> ❒ Ulcerative Colitis Pediatric 80mg/0.8ml Pen Starter Pack (4 pens) CF ($\geq 40kg$) ❒ Humira pen 40mg/0.4ml carton (2 pens) CF ($20-39kg$)	<u>Initial Dose Ulcerative Colitis:</u> ❒ Inject 160mg SQ on day 1 then 80mg on day 8 & 15 ❒ Inject 80mg SQ on day 1 & 2 then 80mg on day 8 & 15 ❒ Inject 80mg SQ on day 1 and 40mg SQ on day 8 & 15		
	<u>Maintenance Dose:</u> ❒ 20mg/0.2ml PFS CF ❒ 40mg/0.4mL pen CF ❒ 40mg/0.4mL PFS CF ❒ 80mg/0.8ml pen CF	❒ Inject 20mg SQ every other week ❒ Inject 20mg SQ once weekly ❒ Inject 40mg SQ every other week ❒ Inject 40mg SQ once weekly ❒ Inject 80mg SQ every other week	❒ 28 Day Supply	_____
❒ Remicade ❒ Inflectra ❒ Renflexis ❒ Avsola ❒ Infliximab	100mg vial	<u>Loading Dose:</u> ❒ Infuse_____ mg IV at week 0, 2, and 6 weeks	❒ 42 Day Supply	0
		<u>Maintenance Dose:</u> ❒ Infuse_____mg IV every 8 weeks	❒ 56 Day Supply	_____

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.