CenterWell Specialty Pharmacy

Fax: 877-405-7940
Phone: 800-486-2668
Monday – Friday, 8 a.m. – 11 p.m., and
Saturday, 8 a.m. – 6:30 p.m., Eastern time

# Dermatology Prescription Form

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

## 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: _____ Diagnosis: _____ Diagnosis date: _____

BSA: _____$m^2$ % BSA affected: _____ Affected areas: ❒ Hands ❒ Feet ❒ Head ❒ Neck ❒ Other: _____

Concurrent medications: _____

Previous therapy: _____ Dates: _____

Discontinuation reason: _____

TB test: ❒ No ❒ Yes Date of negative TB test: _____

HBV: ❒ No ❒ Yes If yes, currently treated? ❒ No ❒ Yes

## Medication

| | | | |
|---|---|---|---|
| ❒ Abrilada | ❒ Dupixent | ❒ Opzelura | ❒ Skyrizi |
| ❒ Adbry | ❒ Enbrel | ❒ Orenica | ❒ Sotyktu |
| ❒ Amjevita | ❒ Hadlima | ❒ Otezla | ❒ Stelara |
| ❒ Avsola | ❒ Hulio | ❒ Remicade | ❒ Taltz |
| ❒ Bimzelx | ❒ Humira | ❒ Renflexis | ❒ Tremfya |
| ❒ Cibinqo | ❒ Hyrimoz | ❒ Rinvoq | ❒ Yuflyma |
| ❒ Cimzia | ❒ Idadcio | ❒ Siliq | |
| ❒ Cosentyx | ❒ Ilumya | ❒ Simponi | |
| ❒ Cyltezo | ❒ Inflectra | ❒ Simponi Aria | |

## Prescription information

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

| Dosage Form | Dose | Directions | Quantity | Refills |
|---|---|---|---|---|
| | Initial Dose | | | |
| | Maintenance Dose | | | |
| | 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.