CenterWell Specialty Pharmacy

Formerly Humana Specialty Pharmacy

Fax

TO: JOHN M. CAFARDI	FROM: CenterWell Specialty Pharmacy
PHONE: (513) 585-2000	PAGES: 2
FAX: (513) 826-5980	DATE: Friday,May 10, 2024

Date and time of transmission: Friday,May 10, 2024 06:00:23 AM

If this transmission is not received in good order, please call the sender at the phone number above or advise by fax to the sender's fax number above.

The information transmitted is intended only for the person or entity to whom it is addressed and may contain **confidential** material. If you receive this material/information in error, contact the sender and delete or destroy the material/information. Thank you.

CenterWell Specialty Pharmacy

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Patient Prescription Request

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

Dear healthcare provider:

A prescription we have on file for HEMKALA ROSKYDAL either is expired or has no refills remaining.

Please e-prescribe—where required by state/federal regulations—or authorize refills on the medication in the space provided and fax with a secure cover sheet to **877-405-7940.**

You can send this prescription electronically (eRx) by selecting "Humana Specialty Pharmacy (Now CenterWell Specialty Pharmacy)" (NCPDP ID # 3677955) from the list of pharmacies on your e-prescribing tool.

CenterWell Specialty Pharmacy™
Date: 5/10/2024

Patient name: HEMKALA ROSKYDAL
Patient address: 1600 PEACEFUL DRIVE, BOLINGBROOK, IL 60490
Date of birth: JUL-23-1942

Drug allergies: _____

Diagnosis(ICD-10 code): _____

Height: _____ Weight: _____

Prescription information

Drug: ENBREL PFS INJ 25MG/0.5ML KIT

Quantity: 90-day supply or _____

Directions: USE AS DIRECTED BY YOUR PHYSICIAN

Refill for one year or _____

Prescriber signature: _____

Prescriber name: CAFARDI, JOHN
Prescriber address: 2123 AUBURN AVENUE, CINCINNATI, OH 45219
DEA number: FC4338136
Phone: (513) 585-2000 Fax: (513) 826-5980

Please provide supervising prescriber information (if applicable):

Name: _____

Address: _____

Phone: _____

DEA number: _____ NPI number:_____

*Note: If all information is not completed, the patient request will not be processed. We will contact your office for clarification.