Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

ASTHMA/ PULMONOLOGY

Chartwell Specialty Pharmacy
Phone: 1-800-366-6020 Fax: 412-920-1869

Date:______________ Auth #: _________________________ Auth Dates: _________________________ ☐ UPMC prior auth form attached

Patient Information

First Name: ______________________ Last Name: ____________________________ DOB: ___________ SSN: _______________ ☐ Male ☐ Female
Address: ______________________________ City: ____________________________ State:_____________ Zip: _______________
Phone: _____________________ Alternate Phone: _______________________ Caregiver/ Emergency Contact: _____________ Phone: ____________
Weight: ____________________ Allergies: ____ Latex Allergy: ☐ Yes ☐ No

Insurance Information

Primary Insurance: ____ Secondary Insurance: ____
Insured: ____ Insured: ____
Phone: ____ Phone: ____
Policy #: _____________________ Group #: _________________________ Policy #: __________________________ Group #: ____________________

ICD 10

Diagnosis
☐ J45.____ Asthma
☐ L50.1 Idiopathic Uticaria
☐ M30.1 Polyarteritis with lung involvement
☐ Other:

Prescription Information

Medication	Dose/ Strength	Directions	Quantity	Refills
☐ Cinqair® (reslizumab)	☐ 100mg/10ml vial	☐ Infuse _______mg every 4 weeks		
☐ Dupixent®	☐ 200mg/1.14ml pfs ☐ 300mg/2ml pfs ☐ 300mg/2ml pen	☐ Administer 300mg under the skin every 2 weeks ☐ Initial Dose: Administer two (total of 400mg) subcutaneously on day 1 then one (200mg) every 2 weeks starting on day 15 and thereafter ☐ Initial Dose: Administer two (total of 600mg) subcutaneously on day 1 then one (300mg) every 2 weeks starting on day 15 and thereafter ☐ Maintenance Dose: Administer 200mg under the skin every 2 weeks ☐ Maintenance Dose: Administer 300mg under the skin every 2 weeks		
☐ Fasenra™	☐ 30mg/ml pen ☐ 30mg/ml pfs	☐ Administer 30mg by subcutaneous injection every 4 weeks for the first 3 doses ☐ Maintenance Dose: Inject 30mg once every 8 weeks		
☐ Nucala®	☐ 100mg vials ☐ 100mg/ml Autoinjector ☐ 100mg/ml Pen	☐ Administer 100mg per dose subcutaneously every 4 weeks ☐ Administer 300mg subcutaneously every 4 weeks		
☐ Tezspire™	☐ 210mg/1.91ml pfs ☐ 210mg/1.91ml pen	☐ Administer 210mg subcutaneously every 4 weeks		
☐ Xolair®	☐ 150mg vials ☐ 75mg/0.5ml pfs ☐ 150mg/ml pfs	☐ Administer 150mg per dose subcutaneously every 4 weeks ☐ Administer 150mg per dose subcutaneously every 2 weeks ☐ Administer____ mg per dose subcutaneously every ☐ 2 weeks ☐ 4 weeks	4-week supply	

Prescriber Information

Date Shipment Needed: ____________________ Ship to: ☐ Patient ☐ Physician/ Clinic ☐ Other: ____
Physician's Name: ___________________________ Office Contact Name: ______________________________ Phone: _________ Fax: ____________
Address: ____ City: __________ State: _____________ Zip: ______________
Physician's Signature: ____ Date: ___________________________

I authorize Chartwell Pennsylvania Specialty Pharmacy and its representatives to act as an agent and execute the insurance prior authorization process.