Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

DERMATOLOGY (A-H)

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

☐ L40.59 Psoriatic Arthritis	☐ L40.1 Generalized Pustular Psoriasis ☐ L40.0P Plaque Psoriasis	☐ Other:

Prescription Information

Medication	Dose/ Strength	Directions	Quantity	Refills
☐ Cibinqo™	☐ 50mg tablet ☐ 100mg tablet ☐ 200mg tablet	☐ 50mg once daily ☐ 100mg once daily ☐ 200mg once daily		
☐ Cimzia®	☐ 200mg prefilled syringes (2 x 200mg) ☐ 200mg lyophilized powder (2 x 200mg)	☐ Initial Dose: Administer 400mg SC at week 0, week 2, and week 4 Followed by Maintenance Dose: ☐ Administer 400mg SC every 4 weeks ☐ Administer 200mg SC every other week ☐ Other:_________________________	☐ 4 week supply ☐ Other:_______	
☐ Cosentyx®	☐ 150mg/1ml PEN ☐ 150mg/1ml Prefilled Syringe	☐ Loading Dose: Inject 300 mg once weekly at weeks 0,1,2,3 and 4 ☐ Maintenance Dose: Inject 300 mg every 4 weeks	☐ 5 week supply ☐ 4 week supply	
☐ Dupixent®	☐ 300mg Prefilled Syringes	☐ Initial Dose: Inject 600mg SC day 1, followed by 300mg given every other week ☐ Maintenance Dose: Inject 300mg SC every other week	☐ 4 syringes ☐ 2 Syringes	None __Refills
☐ Enbrel®	☐ 50mg/ml Sureclick™ Autoinjector ☐ 50mg/ml Prefilled Syringe ☐ 50 mg/ml Enbrel Mini ☐ 25mg/0.5ml Prefilled Syringe ☐ 25mg Vial (inj. Supplies incl)	☐ Inject 50mg SC ONCE a week ☐ Inject 50mg SC TWICE a week ☐ Inject 25mg SC TWICE a week	4 week supply	
☐ Humira®	☐ 40mg/0.8ml PEN ☐ 40mg/0.8ml Prefilled Syringe	☐ Inject 80mg SC on Day 1 ☐ Inject 40mg SC on Day 8 ☐ Inject 40mg SC on Day 22 ☐ Maintenance Dose: Inject 40mg SC every other week	4 week supply	
☐ Ilumya™	☐ 100mg/ml Prefilled Syringe	☐ Initial Dose: Inject 100 mg at weeks 0 and 4 and every 12 weeks ☐ Maintenance Dose: Inject 100 mg every 12 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.