Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

DERMATOLOGY (T-Z)

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: _____
Insured: _____
Phone: _____
Policy #: _____ Group #: _____

Secondary Insurance: _____
Insured: _____
Phone: _____
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
☐ Taltz®	☐ 80mg Autoinjector pen ☐ 80mg Prefilled syringe	☐ Inject 160mg at week 0, followed by 80 mg at weeks 2, 4, 6, 8, 10 and 12 ☐ Maintenance Dose: Inject 80mg every 4 weeks		
☐ Tremfya®	☐ 100mg/ml PFS ☐ 100mg/ml Pen	☐ Initial Dose: 100mg administered by SC at weeks 0, Week 4 ☐ Maintenance Dose: 100mg every 8 weeks		

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.