Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

GASTROENTEROLOGY (J-R)

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

Crohns Disease
☐ K50.00 Regional enteritis, small intestine
☐ K50.80 Regional enteritis, small & large intestine
☐ K50.10 Regional enteritis, large intestine
☐ K50.90 Regional enteritis, unspecified site

Fistula (Secondary to Crohns disease)
☐ K60.3 Anal fistula
☐ K63.2 Fistula of intestine, excluding rectum and anus

Ulcerative Colitis
☐ K51.80 Ulcerative (chronic) enterocolitis
☐ K51.20 Ulcerative (chronic) proctitis
☐ K51.50 Left-sided ulcerative (chronic) colitis
☐ K51.80 Other ulcerative colitis
☐ K51.80 Ulcerative (chronic) ileocolitis
☐ K51.30 Ulcerative (chronic) proctosigmoiditis
☐ K51.00 Universal ulcerative (chronic) colitis
☐ K51.90 Ulcerative colitis, unspecified

☐ Other:

Prescription Information

Medication	Dose/ Strength	Directions	Quantity	Refills
☐ Ocaliva™	☐ 5mg tablets ☐ 10mg tablets	☐ 5mg orally once daily ☐ 10mg orally once daily ☐ Other:_________________________	30	
☐ Remicade® (infliximab)	Dose:________mg/kg Total dose:________mg Patient Weight: _________	LOADING DOSE ☐ Administer IV at 0, 2, and 6 weeks ☐ Other:_______________________ MAINTENANCE DOSE ☐ Administer IV every 8 weeks ☐ Other:_______________q weeks ☐ Line care per protocol/ Ana Kit		
☐ Renflexis® (infliximab-abda)	Dose:________mg/kg Total dose:________mg Patient Weight: _________	LOADING DOSE ☐ Administer IV at 0, 2, and 6 weeks ☐ Other:_______________________ MAINTENANCE DOSE ☐ Administer IV every 8 weeks ☐ Other:_______________q weeks ☐ Line care per protocol/ Ana Kit		
☐ Rinvoq®	☐ 15mg tablets ☐ 30mg tablets ☐ 45mg tablets	LOADING DOSE ☐ 45mg by mouth once daily for ________ week/s ☐ 30 mg by mouth once daily for ________ week/s MAINTENANCE DOSE ☐ 15mg by mouth once daily ☐ 30mg by mouth once daily		

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.