Home Infusion & Specialty Pharmacy
CHARTWELL℠

INVEGA®, RISPERDAL®, ABILIFY®, VIVITROL®
Referral Form

FAX: (412) 920-1869 PHONE: (800) 366-6020

Auth #: _____ Auth Dates: _____ ☐ UPMC prior Auth form attached

Patient Information

Date: _____ Patient SS#: _____ ☐ Male ☐ Female

Patient's First Name: _____ Patient's Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Alternate Phone #: _____

DOB: _____ Wt: _____ Caregiver/Emergency Contact: _____ Phone #: _____

Allergies: _____ Latex: ☐ Yes ☐ No

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Insured: _____ Insured: _____

Phone: _____ Phone: _____

Policy #: _____ Grp #: _____ Policy #: _____ Grp #: _____

ICD10

Diagnosis:

☐ ICD-10 Code: _____

Prescription

Medication	Dose/Strength	Directions	Quantity	Refills
	Initial Dose: ☐ Day 1: 234 mg (1.5mL) ☐ Day 8: 156 mg (1.0 mL)	234 mg on treatment day 1 followed by 156 mg 1 week later.	1	0
☐ INVEGA SUSTENNA®	**Monthly Maintenance Dose:** ☐ 39 mg (0.25 mL) ☐ 78 mg (0.5 mL) ☐ 117 mg (0.75 mL) ☐ 156 mg (1.0 mL) ☐ 234 mg (1.5 mL)	_____mg IM monthly as directed	1	
☐ RISPERDAL CONSTA®	☐ 12.5 mg (2mL) ☐ 25 mg (2mL) ☐ 37.5 mg (2mL) ☐ 50 mg (2mL)	_____mg IM every 2 weeks as directed	2 (28 day supply)	
☐ ABILIFY MAINTENA®	☐ 400 mg ☐ 300 mg	_____mg IM every 4 weeks	1-month supply	
☐ VIVITROL®	☐ 380 mg	380 mg IM every 4 weeks	1	

Prescriber Information

Date Shipment Needed: _____ Ship to: Patient _____ Physician/Clinic _____

Ship to Other: _____

Physician's Name (please print): _____

Office Contact Name: _____

Phone #: _____ Fax #: _____

Office Address: _____ City: _____ State: _____ Zip: _____

Physician's Signature: _____

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