Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

RHEUMATOLOGY (I-O)

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: ☐ M06.9 Rheumatoid Arthritis ☐ M45.9 Ankylosing Spondylitis	☐ M33.00 Juvenile Rheumatoid Arthritis ☐ L40.52 Psoriatic Arthritis	☐ Other: _____

Prescription Information

Medication	Dose/ Strength	Directions	Quantity	Refills
☐ Ilaris®	☐ 150mg/ml vial Total dose: _____mg	☐ Inject 4mg/kg SC every 4 weeks		
☐ Inflectra® LOADING DOSE 100MG SINGLE-DOSE VIALS ☐ Inflectra® MAINTENANCE DOSE 100MG SINGLE-DOSE VIALS	Dose:_____mg/kg Total dose:_____mg Dose:_____mg/kg Total dose:_____mg	☐ Administer at 0, 2, and 6 weeks ☐ Other:_____ ☐ Administer every 8 weeks ☐ Other:_____q weeks	☐ _____ vials	None
☐ Kevzara®	☐ 150mg Prefilled Syringes ☐ 200mg Prefilled Syringes ☐ 150mg Prefilled Pen ☐ 200mg Prefilled Pen	☐ Inject 150mg SC every 2 weeks ☐ Inject 200mg SC every 2 weeks	4-week supply	
☐ Kineret®	☐ 100mg/0.67ml syringe ☐ 100mg/0.67ml prefilled pen	☐ Inject 100mg SC everyday ☐ Other:		
☐ Olumiant®	☐ 1mg ☐ 2mg	☐ 2mg once daily ☐ Other:		
☐ Orencia®	☐ 500mg less than 60kg ☐ 750mg 60-100kg ☐ 1000mg over 100kg	☐ Infuse over 30 minutes at 0, 2, 4 weeks **-THEN-** ☐ Infuse over 30 minutes monthly as directed	☐ 2-week supply ☐ 4-week supply	
	☐ 125mg pre-filled syringes	☐ Inject 125mg SQ once weekly	☐ 4-week supply	
☐ Otezla®	☐ 30mg tablet	1 tablet twice daily	60 tablets	
☐ Otezla® Starter Pack	Day 1: 10mg in morning Day 2: 10mg in morning and in evening Day 3: 10mg in morning; 20mg in evening	Day 4: 20mg in morning and in evening Day 5: 20mg in morning; 30mg in evening Day 6: 30mg in morning and in evening	1 (one) pack	

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.