Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

ORTHOPAEDICS

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

☐ M45.9 Ankylosing Spondylitis
☐ M17.10 OA-Knee
☐ M17.11 Unilateral primary osteoarthritis, right knee
☐ M17.12 Unilateral primary osteoarthritis, left knee
☐ Other:

Prescription Information

Medication	Dose/ Strength	Directions	Quantity
☐ Euflexxa®	20mg/ 2ml	Inject 20mg intra-articularly once weekly	☐ 3 syringes ☐ 6 syringes (bilateral only)
☐ Durolane®	20mg/ml	Inject 60mg (3ml) once	☐ 1 syringe ☐ 2 syringes (bilateral only)
☐ Gel-One®	30mg/ 3ml	Inject 30mg intra-articularly one time	☐ 1 syringe ☐ 2 syringes (bilateral only)
☐ Gelsyn-3®	16.8mg/ 2ml	Inject 16.8 mg (2 ml) once weekly for 3 weeks (total of 3 injections)	☐ 3 syringes ☐ 6 syringes (bilateral only)
☐ Hyalgan®	20mg/ 2ml	Inject 20mg intra-articularly once weekly	☐ 3 syringes ☐ 5 syringes ☐ 6 syringes (bilateral only) ☐ 10 syringes (bilateral only)
☐ Monovisc®	88mg/ 4ml	Inject 88mg intra-articularly one time	☐ 1 syringe ☐ 2 syringes (bilateral only)
☐ Orthovisc®	30mg/ 2ml	Inject 30mg intra-articularly once weekly	☐ _____ syringes
☐ Supartz®	25mg/ 2.5ml	Inject 25mg intra-articularly once weekly	☐ 3 syringes ☐ 5 syringes ☐ 6 syringes (bilateral only) ☐ 10 syringes (bilateral only)
☐ Synvisc®	16mg/ 2ml	Inject 16mg intra-articularly once weekly	☐ 3 syringes ☐ 6 syringes (bilateral only)
☐ Synvisc-One®	48mg/ 6ml	Inject 48mg intra-articularly one time	☐ 1 syringe ☐ 2 syringes (bilateral only)
☐ Visco-3™	25mg/ 2.5ml	Inject 25mg intra-articularly once weekly	☐ 3 syringes ☐ 6 syringes (bilateral only)

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.

Updated: 08/26/20