

Remicade® Referral Form

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

Patient Information	Date: _____ Patient SS#: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female
	Patient's First Name: _____ Patient's Last Name: _____
	Address: _____ City: _____ State: _____ Zip: _____
	Phone #: _____ Alternate Phone #: _____
	DOB: _____ Wt: _____ Caregiver/Emergency Contact: _____ Phone #: _____
	Allergies: _____ Latex: <input type="checkbox"/> Yes <input type="checkbox"/> No

Insurance Information	Primary Insurance: _____ Secondary Insurance: _____
	Insured: _____ Insured: _____
	Phone: _____ Phone: _____
	Policy #: _____ Grp #: _____ Policy #: _____ Grp #: _____

ICD9	Diagnosis:	<input type="checkbox"/> 555.0 Regional enteritis, small intestine	Ulcerative Colitis	<input type="checkbox"/> 556.0 Ulcerative (chronic) enterocolitis
	Crohn's Disease	<input type="checkbox"/> 555.1 Regional enteritis, large intestine		<input type="checkbox"/> 556.1 Ulcerative (chronic) ileocolitis
		<input type="checkbox"/> 555.2 Regional enteritis, small and large intestine		<input type="checkbox"/> 556.2 Ulcerative (chronic) proctitis
		<input type="checkbox"/> 555.9 Regional enteritis, unspecified site		<input type="checkbox"/> 556.3 Ulcerative (chronic) proctosigmoiditis
	Fistula (secondary to Crohn's disease)	<input type="checkbox"/> 565.1 Anal fistula		<input type="checkbox"/> 556.5 Left-sided ulcerative (chronic) colitis
		<input type="checkbox"/> 569.81 Fistula of intestine, excluding rectum and anus		<input type="checkbox"/> 556.6 Universal ulcerative (chronic) colitis
	Rheumatoid Arthritis	<input type="checkbox"/> 714.0 Rheumatoid arthritis		<input type="checkbox"/> 556.8 Other ulcerative colitis
		<input type="checkbox"/> 714.2 Other RA with visceral or systemic involvement		<input type="checkbox"/> 556.9 Ulcerative colitis, unspecified
	Ankylosing Spondylitis	<input type="checkbox"/> 720.0 Ankylosing spondylitis	Psoriatic Arthritis	<input type="checkbox"/> 696.0 Psoriatic arthropathy
	Other	<input type="checkbox"/> _____	Psoriasis	<input type="checkbox"/> 696.1 Psoriasis

Prescription	Medication	Dose/Strength	Directions	Quantity	Refills
	<input type="checkbox"/> Remicade® 100mg single dose vials LOADING DOSE	Dose: _____ mg/kg Total dose: _____ mg	Infuse as directed	<input type="checkbox"/> 6 week supply <input type="checkbox"/> Other	None
	<input type="checkbox"/> Remicade® 100mg single dose vials MAINTENANCE DOSE	Dose: _____ mg/kg Total dose: _____ mg	Infuse as directed	<input type="checkbox"/> _____ vials	

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.

PHONE: (800) 755-4704

FAX: (412) 920-1869