Avonex®, Betaseron®, Copaxone®, Rebif® Referral Form

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 #: ______

ICD9

Diagnosis: ☐ 340 Multiple Sclerosis ☐ Other: ____________

Prescription

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Avonex®	☐ 30 mcg PFS ☐ 30 mcg Vial	☐ Inject 30mcg IM once weekly	☐ 4-week supply	
☐ Betaseron®	☐ 0.0625mg ☐ 0.125mg ☐ 0.1875mg	☐ Inject SC every other day for two weeks (weeks 1&2) ☐ Inject SC every other day for two weeks (weeks 3&4) ☐ Inject SC every other day for two weeks (week 5&6)	☐ 2 week supply ☐ 2 week supply ☐ 2 week supply	
	☐ 0.25mg	☐ Inject SC every other day	☐ 4 week supply	
☐ Copaxone®	☐ 20mg	☐ Inject 20mg SC daily	☐ 4-week supply	
☐ Rebif®	☐ Titration Pack	☐ Inject 8.8mcg SC three times weekly for two weeks, followed by 22mcg SC three times weekly for two weeks	☐ 4 week supply	
	☐ 22mcg ☐ 44mcg	☐ Inject 22mcg SC three times weekly ☐ Inject 44mcg SC three times weekly	☐ 4 week supply ☐ 4 week supply	

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