Cimzia®
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: ☐ 714.0 Rheumatoid Arthritis

Prescription

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Cimzia® ***Prefilled Syringe***	200mg ***Prefilled Syringes*** (2x200mg) NDC: 50474-710-79	*Initial Dose:* ☐ Inject 400mg SC at weeks 0, 2, and 4	6-week supply	
		Maintenance Dose: ☐ Inject 400mg SC every 4 weeks ☐ Inject 200mg SC every 2 weeks	4-week supply	
☐ Cimzia® ***Lyophilized Powder***	200mg ***Lyophilized Powder*** (2x200mg) NDC: 50474-700-62	*Initial Dose:* ☐ Inject 400mg SC at weeks 0, 2, and 4	6-week supply	
		Maintenance Dose: ☐ Inject 400mg SC every 4 weeks ☐ Inject 200mg SC every 2 weeks	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