



Enbrel[®], Humira[®], Simponi[®], Cimzia[®] 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"/> 714.0 Rheumatoid Arthritis <input type="checkbox"/> 714.3 Juvenile Rheumatoid Arthritis <input type="checkbox"/> 696.0 Psoriatic Arthritis |
| | <input type="checkbox"/> 720.0 Ankylosing Spondylitis <input type="checkbox"/> Other: _____ |

| Prescription | Medication | Dose/Strength | Directions | Quantity | Refills |
|---|---|--|--|---------------|---------|
| | <input type="checkbox"/> Enbrel [®] | <input type="checkbox"/> 50mg/ml Sureclick™ Autoinjector | <input type="checkbox"/> Inject 50mg SC ONCE a week | 4-week supply | |
| | | <input type="checkbox"/> 50mg/ml Prefilled Syringe | <input type="checkbox"/> Inject 50mg SC TWICE a week | | |
| | | <input type="checkbox"/> 25mg/0.5ml Prefilled Syringe | <input type="checkbox"/> Inject 25mg SC TWICE a week | | |
| | | <input type="checkbox"/> 25mg Vial (<i>inj. Supplies incl</i>) | | | |
| | <input type="checkbox"/> Humira [®] | <input type="checkbox"/> 40mg/0.8ml PEN | <input type="checkbox"/> Inject 40mg SC ever OTHER week | 4-week supply | |
| <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe | | <input type="checkbox"/> Inject 40mg SC ONCE a week | | | |
| <input type="checkbox"/> Simponi [®] | <input type="checkbox"/> 50mg/0.5ml Autoinjector | <input type="checkbox"/> Inject 1 single-use Autoinjector SC once monthly | 1 (one) | | |
| | <input type="checkbox"/> 50mg/0.5ml Prefilled Syringe | <input type="checkbox"/> Inject 1 single-use Prefilled Syringe SC once monthly | | | |
| | <input type="checkbox"/> Cimzia [®] Prefilled Syringe | 200mg Prefilled Syringes (2x200mg) NDC: 50474-710-79 | <u>Initial Dose:</u> <input type="checkbox"/> Inject 400mg SC at weeks 0, 2, and 4 | 6-week supply | |
| | | | <u>Maintenance Dose:</u> <input type="checkbox"/> Inject 400mg SC every 4 weeks <input type="checkbox"/> Inject 200mg SC every 2 weeks | 4-week supply | |
| | <input type="checkbox"/> Cimzia [®] Lyophilized Powder | 200mg Lyophilized Powder (2x200mg) NDC: 50474-700-62 | <u>Initial Dose:</u> <input type="checkbox"/> Inject 400mg SC at weeks 0, 2, and 4 | 6-week supply | |
| | | | <u>Maintenance Dose:</u> <input type="checkbox"/> Inject 400mg SC every 4 weeks <input type="checkbox"/> 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