



Enbrel[®], Humira[®], Simponi[®] 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"/> 50mg/ml Prefilled Syringe <input type="checkbox"/> 25mg Vial (<i>inj. Supplies incl</i>)	<input type="checkbox"/> Inject 50mg SC ONCE a week <input type="checkbox"/> Inject 50mg SC TWICE a week <input type="checkbox"/> Inject 25mg SC TWICE a week	4-week supply	
<input type="checkbox"/>	Humira [®]	<input type="checkbox"/> 40mg/0.8ml PEN <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe	<input type="checkbox"/> Inject 40mg SC ever OTHER week <input type="checkbox"/> Inject 40mg SC ONCE a week	4-week supply	
<input type="checkbox"/>	Simponi [®]	<input type="checkbox"/> 50mg/0.5ml Autoinjector <input type="checkbox"/> 50mg/0.5ml Prefilled Syringe	<input type="checkbox"/> Inject 1 single-use Autoinjector SC once monthly <input type="checkbox"/> Inject 1 single -use Prefilled Syringe SC once monthly	1 (one)	

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