



Orencia[®], Rituxan[®], Actemra[®] 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"/>	Orencia [®]	<input type="checkbox"/> 500mg less than 60kg <input type="checkbox"/> 750mg 60-100kg <input type="checkbox"/> 1000mg over 100kg	Infuse over 30 minutes every 2 weeks x 2 -then- Infuse over 30 minutes monthly as directed	<input type="checkbox"/> 2-week supply <input type="checkbox"/> 4-week supply	0
<input type="checkbox"/>	Rituxan [®]	<input type="checkbox"/> 1000mg <input type="checkbox"/> _____mg	Infuse as directed on: <input type="checkbox"/> Day 1 <input type="checkbox"/> Day 15	<input type="checkbox"/> 1-week supply <input type="checkbox"/> 2-week supply	
<input type="checkbox"/>	Actemra [®]	<input type="checkbox"/> 4mg/kg <input type="checkbox"/> 8mg/kg	<input type="checkbox"/> Infuse IV every 4 weeks over one hour or as directed	<input type="checkbox"/> 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