Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

CARDIOLOGY

Chartwell Specialty Pharmacy
Phone: 1-800-366-6020 Fax: 412-920-1869

Date:_____ Auth #: _____ Auth Dates: _____ ☐ UPMC prior auth form attached

Patient Information

First Name: _____ Last Name: _____ DOB: _____ SSN: _____ ☐ Male ☐ Female
Address: _____ City: _____ State:_____ Zip: _____
Phone: _____ Alternate Phone: _____ Caregiver/ Emergency Contact: _____ Phone: _____
Weight: _____ Allergies: _____ Latex Allergy: ☐ Yes ☐ No

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____
Insured: _____ Insured: _____
Phone: _____ Phone: _____
Policy #: _____ Group #: _____ Policy #: _____ Group #: _____

ICD 10

Diagnosis	
☐	☐ Other:

Prescription Information

Medication	Dose/ Strength	Directions	Quantity	Refills
☐ Evkeeza™ (Evinacumab-Dgnb)	☐ 15mg/kg	☐ _____mg intravenously every 4 weeks		
☐ Leqvio® (Inclisiran)	☐ 284mg	☐ Administered 284mg subcutaneously now and at 3 months	1	1
		☐ Administered 284mg subcutaneously every 6 months	1	
☐ Praluent® (Alirocumab)	☐ 75mg Prefilled Syringe Kit ☐ 75mg Pen Kit ☐ 150mg Prefilled Syringe Kit ☐ 150mg Pen Kit	☐ Inject 75mg subcutaneously every 2 weeks ☐ Inject 150mg subcutaneously every 2 weeks	#2 (28-day supply)	
☐ Repatha® (Evolocumab)	☐ 140mg/1ml Sureclick	☐ Inject 140mg subcutaneously every 2 weeks ☐ Inject 420mg subcutaneously once monthly	☐ #2 (28-day supply) ☐ #3 (28-day supply)	

Prescriber Information

Date Shipment Needed: _____ Ship to: ☐ Patient ☐ Physician/ Clinic ☐ Other: _____
Physician's Name: _____ Office Contact Name: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____
Physician's Signature: _____ Date: _____

I authorize Chartwell Pennsylvania Specialty Pharmacy and its representatives to act as an agent and execute the insurance prior authorization process.

Updated: 01/10/22