Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

DERMATOLOGY (I-S)

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

☐ L40.59 Psoriatic Arthritis | ☐ L40.1 Generalized Pustular Psoriasis | ☐ L40.0P Plaque Psoriasis | ☐ Other:

Prescription Information

Medication	Dose/ Strength	Directions	Quantity	Refills
☐ Inflectra® LOADING DOSE 100MG SINGLE-DOSE VIALS ☐ Inflectra® MAINTENANCE DOSE 100MG SINGLE-DOSE VIALS	Dose:_____mg/kg Total dose:_____mg Dose:_____mg/kg Total dose:_____mg	☐ Administer at 0, 2, and 6 weeks ☐ Other:_____ ☐ Administer every 8 weeks ☐ Other:_____q weeks	☐ _____ vials	None
☐ Opzelura™	60g tube	Apply a thin layer twice daily to affected areas.	1 tube	
☐ Otezla®	Day 1: 10mg in morning Day 2: 10mg in morning and in evening Day 3: 10mg in morning; 20mg in evening	Day 4: 20mg in morning and in evening Day 5: 20mg in morning; 30mg in evening Day 6: 30mg in morning and in evening	1 Pack	
☐ Remicade® LOADING DOSE 100MG SINGLE-DOSE VIALS ☐ Remicade® MAINTENANCE DOSE 100MG SINGLE-DOSE VIALS	Dose:_____mg/kg Total dose:_____mg Dose:_____mg/kg Total dose:_____mg	☐ Administer at 0, 2, and 6 weeks ☐ Other:_____ ☐ Administer every 8 weeks ☐ Other:_____q weeks	☐ _____ vials	None
☐ Siliq™	☐ 210mg Prefilled syringe ☐ 1.5ml Prefilled syringe	☐ Initial Dose: Inject 210mg at weeks 0,1 and 2 ☐ Maintenance Dose: Inject 210mg every 2 weeks	1 month supply	
	Prescribers must be certified in the SILIQ REMS Program https://siliqrems.com/SiliqUI/home.u			
☐ Skyrizi™	☐ 150mg Pen ☐ 150mg PFS	☐ Initial Dose:: Inject 150mg SC at weeks 0 and 4 ☐ Maintenance Dose: Inject 150mg SC every 12 weeks		
☐ Stelara®	☐ 45mg Prefilled syringe ☐ 90mg Prefilled syringe	Initial Dose: (Dosed by weight) ☐ 100kg or less -> 45mg SC at weeks 0 and 4 ☐ Greater than 100kg -> 90mg SC at weeks 0 and 4 Maintenance Dose: ☐ 100kg or less -> 45mg every 12 weeks thereafter ☐ Greater than 100kg -> 90mg SC every 12 weeks thereafter		

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.