Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

GASTROENTEROLOGY (A-I)

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: _____
Insured: _____
Phone: _____
Policy #: _____ Group #: _____

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

ICD 10

Crohns Disease
☐ K50.00 Regional enteritis, small intestine
☐ K50.80 Regional enteritis, small & large intestine
☐ K50.10 Regional enteritis, large intestine
☐ K50.90 Regional enteritis, unspecified site

Fistula (Secondary to Crohns disease)
☐ K60.3 Anal fistula
☐ K63.2 Fistula of intestine, excluding rectum and anus

Ulcerative Colitis
☐ K51.80 Ulcerative (chronic) enterocolitis
☐ K51.20 Ulcerative (chronic) proctitis
☐ K51.50 Left-sided ulcerative (chronic) colitis
☐ K51.80 Other ulcerative colitis
☐ K51.80 Ulcerative (chronic) ileocolitis
☐ K51.30 Ulcerative (chronic) proctosigmoiditis
☐ K51.00 Universal ulcerative (chronic) colitis
☐ K51.90 Ulcerative colitis, unspecified

☐ Other:

Prescription Information

Medication	Dose/ Strength	Directions	Quantity	Refills
☐ Avsola® (infliximab-axxq)	Dose:_____mg/kg Total dose:_____mg Patient Weight: _____	LOADING DOSE ☐ Administer IV at 0, 2, and 6 weeks ☐ Other:_____ MAINTENANCE DOSE ☐ Administer IV every 8 weeks ☐ Other:_____q weeks ☐ Line care per protocol/ Ana Kit		
☐ Cimzia®	☐ 200mg prefilled syringes (2 x 200mg) ☐ 200mg vial (2 x 200mg)	☐ Initial Dose: Administer 400mg SC at week 0, week 2, and week 4 Followed by Maintenance Dose: ☐ Administer 400mg SC every 4 weeks ☐ Administer 200mg SC every other week ☐ Other:_____	☐ 4 week supply ☐ Other:_____	
☐ Entyvio®	☐ 300mg	☐ Administer IV at 0, 2, 6 weeks and then every 8 weeks after ☐ Administer IV every 8 weeks ☐ Other:_____q weeks ☐ Line care per protocol/ Ana Kit	☐ 3 vials ☐ 1 vial	
☐ Humira®	☐ Pen-CD/UC/HS Starter	☐ 160mg SC (day 1) then 80mg 2 weeks later (day 15)	☐ 1Kit	
	☐ 40mg Pen ☐ 40mg PFS	Maintenance Dose: ☐ 40mg SC every other week ☐ 40mg SC every week	☐ 1 Kit ☐ 2 Kit	
☐ Inflectra® (infliximab-dyyb)	Dose:_____mg/kg Total dose:_____mg Patient Weight: _____	LOADING DOSE ☐ Administer IV at 0, 2, and 6 weeks ☐ Other:_____ MAINTENANCE DOSE ☐ Administer IV every 8 weeks ☐ Other:_____q weeks ☐ Line care per protocol/ Ana Kit		
☐ Infliximab (unbranded)	Dose:_____mg/kg Total dose:_____mg Patient Weight: _____	LOADING DOSE ☐ Administer IV at 0, 2, and 6 weeks ☐ Other:_____ MAINTENANCE DOSE ☐ Administer IV every 8 weeks ☐ Other:_____q weeks ☐ Line care per protocol/ Ana Kit		

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.