Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

GASTROENTEROLOGY (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: _____

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
☐ Simponi®	☐ 100mg Smartject Autoinjector ☐ 100mg PFS	☐ Initial Dose: Inject 200mg SC at week 0, inject 100mg SC at week 2 ☐ Maintenance Dose: Inject 100mg SC every 4 weeks	☐ 4 week supply	
☐ Skyrizi®	☐ Initial Dose: 600mg/10ml Vial Maintenance Dose: ☐ 180mg ☐ 360mg	☐ Initial Dose: Administer 600mg IV at week 0, week 4, and week 8 ☐ Other:_____ ☐ Line care per protocol/ Ana Kit Maintenance Dose: ☐ Administer 180mg SC via the On-Body Injector at week 12 and every 8 weeks thereafter ☐ Administer 360mg SC via the On-Body Injector at week 12 and every 8 weeks thereafter ☐ Other:_____		
☐ Stelara®	Patient Weight:_____ ☐ 130mg/26mL (5mg/mL) single-dose vial ☐ 90mg Prefilled syringe	Initial IV Dose: (Dosed by weight) ☐ 55kg or less--> 260mg = 2 vials ☐ 85kg--> 520mg = 4 vials ☐ 55kg to 85kg--> 390mg = 3 vials ☐ Line care per protocol/ Ana Kit	☐ 2 vials ☐ 3 vials ☐ 4 vials	None
		Maintenance Dose: ☐ Inject 90mg SC every 4 weeks beginning 4 weeks after intital dose ☐ Inject 90mg SC every 6 weeks beginning 6 weeks after intital dose ☐ Inject 90mg SC every 8 weeks beginning 8 weeks after intital dose	☐ 1 syringe	

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: 06/29/23