CHARTWELL
Home Infusion & Specialty Pharmacy
— PENNSYLVANIA, LP —

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:
☐ G35 Multiple Sclerosis   ☐ Other: _____

Prescription Information

Medication	Dose/ Strength	Directions	Quantity	Refills
☐ Aubagio®	☐ 7mg tablet ☐ 14mg tablet	☐ Take one 7mg tablet by mouth once a day. ☐ Take one 14mg tablet by mouth once a day	☐ 30-day supply ☐ Other:_____	

☐ Avonex®	☐ 30mcg prefilled syringe (PFS)
	☐ 30mcg pen (single dose)
		☐ **Dose Titration:**
		  Week 1: Inject 7.5mcg intramuscularly weekly
		  Week 2: Inject 15mcg intramuscularly weekly
		  Week 3: Inject 22.5mcg intramuscularly weekly
		  Week 4+: Inject 30mcg intramuscularly weekly
		☐ **Maintenance Dose:** Inject 30mcg intramuscularly once weekly.
			☐ 4-week supply (1 kit)	

☐ Bafiertam™	☐ 95mg capsule	☐ **Initial Dose:** One 95mg capsule by mouth twice a day for 7 days ☐ **Maintenance Dose:** Two 95mg capsules by mouth twice a day	☐ 120 capsules	

☐ Betaseron®	☐ 0.3mg vial kit	☐ **Dose Titration:**
		  Weeks 1–2: Inject 0.0625mg/0.25mL subcutaneously every other day
		  Weeks 3–4: Inject 0.125mg/0.50mL subcutaneously every other day
		  Weeks 5–6: Inject 0.1875mg/0.75mL subcutaneously every other day
		  Weeks 7+: Inject 0.25mg/1mL subcutaneously every other day
		☐ **Maintenance Dose:** Inject 0.25mg (1mL) SQ every other day.
		☐ Other:_____
			☐ 28-day supply (1 kit/14 vials)
			☐ Other:_____	

☐ Copaxone® ☐ Glatiramer Acetate ☐ Glatopa®	☐ 20mg PFS	☐ Inject 20mg subcutaneously daily ☐ Other:_____	☐ 30-day supply (1 kit/30 syr)	
	☐ 40mg PFS	☐ Inject 40mg subcutaneously three times a week	☐ 28-day supply (1 kit/12 PFS)	

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: _____