Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

NEUROLOGY: MS D-O

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

Diagnosis:
☐ G35 Multiple Sclerosis ☐ Other:

Prescription Information

Medication	Dose/ Strength	Directions	Quantity	Refills
☐ Dalfampridine	☐ 10mg ER tablet	Take one tablet by mouth every 12 hours	☐ 30-day supply	
☐ Extavia®	☐ 0.3mg vial	☐ **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 0.25 mg (1mL) SQ every other day.	☐ 30-day supply	
☐ Gilenya®	☐ 0.5mg capsule	Take one 0.5mg capsule by mouth once daily	☐ 30 capsules	
☐ Mayzent®	☐ 0.25mg tablets ☐ 2mg tablets Genotype: _____	**All doses taken by mouth.** ☐ **Titration for 1mg** maintenance dose: Day 1: 1 x 0.25mg, Day 2: 1 x 0.25mg, Day 3: 2 x 0.25mg, Day 4: 3 x 0.25mg, Day 5: 4 x 0.25mg ☐ **Maintenance 1mg** 4 tablets of 0.25mg by mouth once daily starting on day 5 ☐ **Maintenance 2mg:** one 2mg tablet by mouth once daily starting on day 6 *2mg starter pack available through manufacturer	☐ 1-month supply ☐ Other:_____	
☐ Ocrevus®	☐ 300mg vial	☐ **Initial Dose:** 300mg Intravenously day 1 and day 15 ☐ **Maintenance Dose:** 600mg IV every 6 months		

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.