Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

RHEUMATOLOGY (A-H)

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: ☐ M06.9 Rheumatoid Arthritis ☐ M45.9 Ankylosing Spondylitis	☐ M33.00 Juvenile Rheumatoid Arthritis ☐ L40.52 Psoriatic Arthritis	☐ Other: _____

Prescription Information

Medication	Dose/ Strength	Directions	Quantity	Refills
☐ Actemra®	☐ 162mg prefilled syringe ☐ 162mg pen	Inject 162 mg subcutaneously: ☐ Every other week ☐ Once per week ☐ Other: _____	☐ 1-month supply ☐ Other:_____	
☐ Actemra® Vials	☐ 80mg ☐ 200mg ☐ 400mg	☐ Dose: _____ ☐ **Loading Dose:** 4mg/kg every 4 weeks ☐ **Maintenance Dose:** 8mg/kg every 4 weeks		
☐ Benlysta® Patient Weight: _____	☐ 120mg vial ☐ 400mg vial	☐ **Loading Dose:** ____every 2 weeks x3 doses ☐ **Maintenance Dose:** ____every 4 weeks		
	☐ 200mg autoinjector ☐ 200mg PFS	☐ 200mg subcutaneously once weekly		
☐ Cimzia®	☐ 200mg Prefilled Syringes (2x200mg) ☐ 200mg Lyophilized Powder Vial (2x200mg)	☐ **Initial Dose:** Inject 400mg SC at weeks 0, 2, and 4 **Maintenance Dose:** ☐ Inject 200mg SC every 2 weeks ☐ Inject 400mg SC every 4 weeks	☐ 4-week supply	
☐ Cosentyx®	☐ 150mg/1ml PEN ☐ 150mg/1ml prefilled syringe	☐ **Loading Dose:** Inject 150mg once weekly at weeks 0, 1, 2, 3, and 4 **Maintenance Dose:** ☐ Inject 150mg every 4 weeks ☐ Inject 300mg every 4 weeks	☐ 5-week supply ☐ 4-week supply	
☐ Enbrel®	☐ 50mg/ml Sureclick™ Autoinjector ☐ 50mg/ml Prefi lled Syringe ☐ 50 mg/ml Enbrel Mini ☐ 25mg/0.5ml Prefilled Syringe ☐ 25mg Vial (inj. Supplies incl)	☐ Inject 50mg SC ONCE a week ☐ Inject 50mg SC TWICE a week ☐ Inject 25mg SC TWICE a week	☐ 4-week supply	
☐ Humira®	☐ 40mg/0.8ml PEN ☐ 40mg/0.8ml Prefilled Syringe	☐ Inject 40mg SC every OTHER week ☐ Other: ☐ Inject 40mg SC ONCE a week ☐ Inject 80mg SC every other week	☐ 4-week supply	

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.