Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

RHEUMATOLOGY/ OSTEOPOROSIS (R-T)

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
☐ Remicade® LOADING DOSE 100MG SINGLE-DOSE VIALS ☐ Remicade® MAINTENANCE DOSE 100MG SINGLE-DOSE VIALS	Dose:_____mg/kg Total dose:_____mg Dose:_____mg/kg Total dose:_____mg	☐ Administer at 0, 2, and 6 weeks ☐ Other:_____ ☐ Administer every 8 weeks ☐ Other:_____q weeks	☐ _____ vials	None
☐ Rinvoq™	☐ 15mg tablet	☐ Take one tablet by mouth daily		
☐ Rituxan®	☐ 1000mg ☐ _____mg	Infuse as directed on: ☐ Day 1 ☐ Day 15		
☐ Saphnelo™	☐ 300mg/2ml vial	☐ Administer 300mg every 4 weeks		
☐ Simponi®	☐ 50mg/0.5ml Smartject ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject SC once monthly	1 (one)	
☐ Simponi Aria® 50mg/4ml vial	Dose: 2mg/kg Total dose:_____mg	☐ **Initial Dose:** Infuse over 30 minutes at weeks 0 and 4 ☐ **Maintenance Dose:** Infuse over 30 minutes every 8 weeks	☐ 4-week supply ☐ _____ vials	NONE
☐ Stelara®	☐ 45mg Prefilled syringe ☐ 90mg Prefilled syringe	Initial Dose: (Dosed by weight) ☐ 100kg or less -> 45mg SC at weeks 0 and 4 ☐ Greater than 100kg -> 90mg SC at weeks 0 and 4 Maintenance Dose: ☐ 100kg or less -> 45mg every 12 weeks thereafter ☐ Greater than 100kg -> 90mg SC every 12 weeks thereafter		
☐ Taltz®	☐ 80mg/ml Autoinjector ☐ 80mg/ml PFS	**Loading Dose:** ☐ 160mg at week 0 ☐ Other: ☐ **Maintenance Dose:** 80mg every 4 weeks		

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.