Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

Xolair®, Nucala® Referral Form

Auth #: ____________ Auth Dates: ____________ ☐ UPMC prior auth form attached

Patient Information

Date: ________ Patient SS#: ____________ DOB: ________ ☐ Male ☐ Female

First Name: ____________ Last Name: ____________

Address: ____________ City: ________ State: ____ Zip: ______

Phone #: ____________ Alternate Phone #: ____________

Caregiver/ Emergency Contact: ____________ Phone #: ____________

Weight:______ Allergies: ____________ Latex allegy: ☐ Yes ☐ No

Insurance

Primary Insurance: ____________

Insured: ____________

Phone: ____________

Policy: ____________ Grp #: ________

Secondary Insurance: ____________

Insured: ____________

Phone: ____________

Policy: ____________ Grp #: ________

ICD10

Diagnosis: ☐ J45.___ Asthma ☐ L50.1 Idiopathic Uticaria ☐ Other: ____________

Prescription

Medication	Dose/ Strength	Directions	Quantity	Refills
Nucala® (mepolizumab)	☐ 100mg vials	Every 4 weeks dosing: ☐ Administer 100mg per dose subcutaneously every 4 weeks	1 vial	
Xolair® (omalizumab)	☐ 150mg vials	☐ Administer 150mg per dose subcutaneously every 4 weeks ☐ Administer 150mg per dose subcutaneously every 2 weeks ☐ Administer ____mg per dose subcutaneously every ☐ 2 weeks ☐ 4 weeks	4 - week supply	

Prescriber Information

Date Shipment Needed: ____________ Ship to: ☐ Patient ☐ Physician/ Clinic

☐ Ship to other: ____________

Physician's Name: ____________ (please print) 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 6/29/17

Fax: (412) 920-1869 Phone: (800) 366-6020