Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

Cosentyx®, Dupixent®, Enbrel®, Humira®, Remicade®, Stelara®, Otezla® Referral Form

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

Patient Information

Date: _____ Patient SS#:_____ ☐ Male ☐ Female

Patient's First Name:_____ Patient's Last Name: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone #: _____ Alternate Phone #:_____

DOB: _____ Wt: _____ Caregiver/Emergency Contact: _____ Phone#: _____

Allergies: _____ Latex: ☐ Yes ☐ No

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Insured: _____ Insured: _____

Phone: _____ Phone: _____

Policy #: _____ Group #: _____ Policy #: _____ Group #: _____

ICD10

Diagnosis: ☐ L40.59 Psoriatic Arthritis ☐ L40.1 Generalized Pustular Psoriasis ☐ L40.0P Plaque Psoriasis
☐ Other: _____

Prescription

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Cosentyx®	☐ 150mg/1ml PEN ☐ 150mg/1ml Prefilled Syringe	☐ Loading Dose– Inject 300 mg once weekly at weeks 0,1,2,3 and 4 ☐ Maintenance Dose– Inject 300 mg every 4 weeks	☐ 5-week supply ☐ 4-week supply	
☐ Dupixent®	☐ 300mg– Prefilled Syringes	☐ Initial Dose– Inject 600mg SC day 1, followed by 300mg given every other week ☐ Maintenance Dose– Inject 300mg SC every other week	☐ 4 syringes ☐ 2 syringes	None ___refills
☐ Enbrel®	☐ 50mg/ml Sureclick™ Autoinjector ☐ 50mg/ml Prefilled Syringe ☐ 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 80mg SC on Day 1 ☐ Inject 40mg SC on Day 8 ☐ Inject 40mg SC on Day 22 ☐ Maintenance Dose– Inject 40mg SC every other week	4-week supply	
☐ Remicade® 100mg single dose vials LOADING DOSE	☐ Dose: _____mg/kg ☐ Total dose:_____mg	☐ Administer at 0, 2, and 6 weeks ☐ Other:_____	☐ 4-week supply ☐ Other	None
☐ Remicade® 100mg single dose vials MAINTENANCE DOSE	☐ Dose: _____mg/kg ☐ Total dose:_____mg	☐ Administer every 8 weeks ☐ Other:_____ weeks	_____ vials	
☐ Stelara®	☐ 45mg/0.5ml in a single - use Prefilled Syringe ☐ 90mg/1ml in a single - use Prefilled Syringe	☐ 45mg SC initially and 4 weeks later (bolus) ☐ 45mg SC every 12 weeks ☐ 90mg SC initially and 4 weeks later (bolus) ☐ 90mg SC every 12 weeks		
☐ Otezla® Starter Pack	Day 1: 10mg in morning Day 2: 10mg in morning and in evening Day 3: 10mg in morning; 20mg in evening Day 4: 20mg in morning and in evening Day 5: 20mg in morning; 30mg in evening Day 6: 30mg in morning and in evening	1 Pack	None	
☐ Otezla ®	☐ 30mg tablet	1 tablet twice daily	60 tablets	

Prescriber Information

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

Ship to Other: _____

Physician's Name (please print): _____

Office Contact Name: _____

Phone #: _____ Fax: _____

Office Address: _____ City: _____ State: _____ Zip:_____

Physician's Signature: _____

I authorize Chartwell Pennsylvania Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Updated 4-19-17