Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

GI Referral Form

Chartwell Specialty Pharmacy
Telephone: 1-800-366-6020 Fax: 412-920-1869

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 allergy: ☐ Yes ☐ No

Insurance

Primary Insurance: ________________________________

Insured: ________________________________

Phone: ________________________________

Policy: ____________________ Grp #: ____________

Secondary Insurance: ________________________________

Insured: ________________________________

Phone: ________________________________

Policy: ____________________ Grp #: ____________

ICD10

Chrohn's Disease
- ☐ K50.00 Regional enteritis, small intestine
- ☐ K50.80 Regional enteritis, small & large intestine
- ☐ K50.10 Regional enteritis, large intestine
- ☐ K50.90 Regional enteritis, unspecified site

Fistula (Secondary to Chrohn's disease)
- ☐ K60.3 Anal fistual
- ☐ K63.2 Fistual of intestine, excluding rectum and anus

Ulcerative Colitis
- ☐ K51.80 Ulcerative (chronic) enterocolitis
- ☐ K51.20 Ulcerative (chronic) proctitis
- ☐ K51.50 Left-sided ulcerative (chronic) colitis
- ☐ K51.80 Other ulcerative colitis
- ☐ K51.80 Ulcerative (chronic) ileocolitis
- ☐ K51.30 Ulcerative (chronic) proctosigmoiditis
- ☐ K51.00 Universal ulcerative (chronic) colitis
- ☐ K51.90 Ulcerative colitis, unspecified

☐ **Other:**

Prescription

Medication	Dose/ Strength	Directions	Quantity	Refills
☐ Cimzia®	☐ 200mg prefilled syringes (2 x 200mg) ☐ 200mg lyophilized powder (2 x 200mg)	☐ **Initial Dose:** Administer 400mg SC at week 0, week 2, and week 4 **Followed by Maintenance Dose:** ☐ Administer 400mg SC every 4 weeks ☐ Administer 200mg SC every other week ☐ Other:____________	☐ 4 week supply ☐ Other:______	
☐ Entyvio® LOADING DOSE ☐ Entyvio® MAINTENANCE DOSE	☐ 300mg ☐ 300mg	☐ Administer at 0, 2, and 6 weeks ☐ Administer every 8 weeks	☐ 3 vials ☐ 1 vial	None
☐ Humira®	☐ 40mg/0.8mL pen (2 pens/ box) ☐ 40mg/0.8mL, prefilled syringe (2 syringes/ box)	☐ **Initial Dose:** Inject 160mg SC on day 1, inject 80mg SC on day 15 ☐ **Maintenance Dose:** Inject 40mg SC every other week	☐ 4 week supply	
☐ Ocaliva®	☐ 5mg ☐ 10mg	☐ **Initial Dose:** 5mg orally once daily ☐ **After 3 months of therapy:** 10mg orally once daily	☐ 30 tablets	
☐ 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
☐ Simponi®	☐ 100mg Smartject Autoinjector	☐ **Initial Dose:** Inject 200mg SC at week 0, inject 100mg SC at week 2 ☐ **Maintenance Dose:** Inject 100mg SC every 4 weeks	☐ 4 week supply	
☐ Stelara®	☐ 130mg/26mL (5mg/mL) single-dose vial	**Initial Dose: (Dosed by weight)** ☐ 55kg or less--> 260mg = 2 vials ☐ 85kg--> 520mg = 4 vials ☐ 55kg to 85kg--> 390mg = 3 vials	☐ 2 vials ☐ 3 vials ☐ 4 vials	☐ None
	☐ 90mg Prefilled syringe	☐ **Maintenance Dose:** Inject 90mg SC every 8 weeks, then every 8 weeks thereafter	☐ 1 syringe	

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 10/11/17