Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

Oral Oncology

Chartwell 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 #: _____ Grp #: _____ Policy #: _____ Grp #: _____

ICD-10

ICD-10 Code:_____ Diagnosis:_____

Prescription

Medication		Dosing & Sig	Refills
☐ Afinitor	☐ Odomzo		
☐ Alecensa	☐ Promacta		
☐ Alunbrig	☐ Rubraca		
☐ Bosulif	☐ Rydapt		
☐ Cabometyx	☐ Sprycel		
☐ Calquence	☐ Stivarga		
☐ Capecitabine	☐ Sutent		
☐ Cotellic	☐ Tafinlar		
☐ Erivedge	☐ Tagrisso		
☐ Erleada	☐ Tarceva		
☐ Farydak	☐ Targretin		
☐ Gleevec	☐ Tasigna		
☐ Hycamtin	☐ Temozolomide		
☐ Ibrance	☐ Tykerb		
☐ Idhifa	☐ Verzenio		
☐ Imatinib	☐ Votrient		
☐ Imbruvica	☐ Xalkori		
☐ Inlyta	☐ Xeloda		
☐ Iressa	☐ Xgeva		
☐ Jadenu	☐ Xtandi		
☐ Jakafi	☐ Zejula		
☐ Kisqali	☐ Zelboraf		
☐ Lonsurf	☐ Zoledronic Acid		
☐ Lynparza	☐ Zolinza		
☐ Mekinist	☐ Zydelig		
☐ Nexavar	☐ Zykadia		
☐ Ninlaro	☐ Zytiga		

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 2-28-18

PHONE: (800) 366-6020 FAX: (412) 920-1869