Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

Rheumatoid Arthritis
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 #: _____

Primary Insurance: _____
Insured: _____
Phone: _____
Policy: _____ Grp #: _____

ICD10

Diagnosis:
☐ M06.9 Rheumatoid Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ M33.00 Juvenile Rheumatoid Arthritis ☐ L40.52 Psoriatic Arthritis ☐ Other: _____

Prescription

Medication	Dose/ Strength	Directions	Quantity	Refills
☐ **Actemra®**	☐ 4mg/kg ☐ 8mg/kg	☐ Infuse IV every 4 weeks over one hour or as directed	☐ 4-week supply	
☐ **Cimzia®**	☐ 200mg Prefilled Syringes (2x200mg) ☐ 200mg Lyophilized Powder Vial (2x200mg)	**Initial Dose:** ☐ Inject 400mg SC at weeks 0, 2, and 4 **Maintenance Dose:** ☐ Inject 400mg SC every 4 weeks ☐ Inject 400mg SC every 2 weeks	☐ 4-week supply ☐ 4-week supply	
☐ **Cosentyx®**	☐ 150mg/1ml PEN ☐ 150mg/1ml pre-filled syringe	**Loading Dose:** ☐ Inject 150mg once weekly at weeks 0, 1, 2, 3, and 4 **Maintenance Dose:** ☐ Inject 150mg every 4 weeks ☐ Inject 300mg every 4 weeks	☐ 5-week supply ☐ 4-week supply	
☐ **Enbrel®**	☐ 50 mg/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 40mg SC every OTHER week ☐ Inject 40mg SC ONCE a week	☐ 4-week supply	
☐ **Kevzara®**	☐ 200 mg Prefilled Syringes	☐ Inject 200mg SC every 2 weeks	4-week supply	
☐ **Orencia®**	☐ 500mg less than 60kg ☐ 750mg 60-100kg ☐ 1000mg over 100kg	☐ Infuse over 30 minutes at 0, 2, 4 weeks **-then-** ☐ Infuse over 30 minutes monthly as directed	☐ 2-week supply ☐ 4-week supply	
	☐ 125mg pre-filled syringes	☐ Inject 125mg SQ once weekly	☐ 4-week supply	
☐ **Otezla®**	☐ 30mg tablet	1 tablet twice daily	60 tablets	
☐ **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 (one) pack	
☐ **Remicade®** 100mg single-dose vials	**Loading Dose:** ☐ Dose: _____mg/kg Total dose: _____mg **Maintenance Dose:** ☐ Dose: _____mg/kg Total dose: _____mg	☐ Administer at 0, 2, and 6 weeks ☐ Other: _____ ☐ Administer every 8 weeks ☐ Other: _____q weeks	☐ _____ vials	NONE
☐ **Rituxan®**	☐ 1000mg ☐ _____mg	**Infuse as directed on:** ☐ Day 1 ☐ Day 15		
☐ **Simponi®**	☐ 50mg/0.5ml Smartject ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject 1 single-use Smartject SC once monthly ☐ Inject 1 single-use Prefilled Syringe 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/0.5ml Prefilled Syringe ☐ 90mg/1ml Prefilled Syringe	☐ 45mg SC initially and 4 weeks later (initial) ☐ 45mg SC every 12 weeks ☐ 90mg SC initially and 4 weeks later (initial) ☐ 90mg SC every 12 weeks		
☐ **Xeljanz®**	☐ 5mg tablets	☐ 5mg twice daily	60 tablets (30-day supply)	
☐ **Xeljanz® XR**	☐ 11mg tablets	☐ 11mg once daily	30 tablets (30-day 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 1/30/18