Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

DERMATOLOGY (A-O)

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

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

Patient Information

First Name: _____ Last Name: _____ DOB: _____ SSN: _____ ☐ Male ☐ Female

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

Phone: _____ Alternate Phone: _____ Caregiver/ Emergency Contact: _____ Phone: _____

Weight: _____ Allergies: _____ Latex Allergy: ☐ Yes ☐ No

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Insured: _____ Insured: _____

Phone: _____ Phone: _____

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

ICD 10

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

Prescription Information

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:_____	
☐ 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	
☐ Ilumya™	☐ 100mg/ml Prefilled Syringe	☐ Initial Dose: Inject 100 mg at weeks 0 and 4 and every 12 weeks ☐ Maintenance Dose: Inject 100 mg every 12 weeks	4 week supply	
☐ Inflectra® LOADING DOSE 100MG SINGLE-DOSE VIALS ☐ Inflectra® 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
☐ Otezla®	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	

Prescriber Information

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

Physician's Name: _____ 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.