Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

DERMATOLOGY (R-Z)

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
☐ 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
☐ Siliq™	☐ 210mg Prefilled syringe ☐ 1.5ml Prefilled syringe	☐ Initial Dose: Inject 210mg at weeks 0,1 and 2 ☐ Maintenance Dose: Inject 210mg every 2 weeks	1 month supply	
	Prescribers must be certified in the SILIQ REMS Program https://siliqrems.com/SiliqUI/home.u			
☐ Skyrizi™	☐ 150mg Kit (2 x 75mg PFS)	☐ Initial Dose:: Inject 150mg (two injections) SC at weeks 0 and 4 ☐ Maintenance Dose: Inject 150mg (two injections) SC every 12 weeks		
☐ Stelara®	☐ 45mg Prefilled syringe ☐ 90mg Prefilled syringe	Initial Dose: (Dosed by weight) ☐ 100kg or less -> 45mg SC at weeks 0 and 4 ☐ Greater than 100kg -> 90mg SC at weeks 0 and 4 Maintenance Dose: ☐ 100kg or less -> 45mg every 12 weeks thereafter ☐ Greater than 100kg -> 90mg SC every 12 weeks thereafter		
☐ Taltz®	☐ 80mg Autoinjector pen ☐ 80mg Prefilled syringe	☐ Inject 160mg at week 0, followed by 80 mg at weeks 2, 4, 6, 8, 10 and 12 ☐ Maintenance Dose: Inject 80mg every 4 weeks		
☐ Tremfya®	☐ 100mg/ml PFS ☐ 100mg/ml Pen	☐ Initial Dose: 100mg administered by SC at weeks 0, Week 4 ☐ Maintenance Dose: 100mg every 8 weeks		

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.

Updated: 06/07/21