Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

GASTROENTEROLOGY (P-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

Crohns 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 Crohns disease)
☐ K60.3 Anal fistula
☐ K63.2 Fistula 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 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 Patient Weight: Dose:_____mg/kg Total dose:_____mg	☐ Administer IV at 0, 2, and 6 weeks ☐ Other:_____ ☐ Administer IV every 8 weeks ☐ Other:_____q weeks	☐ _____ vials	
☐ Simponi®	☐ 100mg Smartject Autoinjector ☐ 100mg PFS	☐ 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®	Patient Weight:_____ ☐ 130mg/26mL (5mg/mL) single-dose vial ☐ 90mg Prefilled syringe	Initial IV 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
		☐ Maintenance Dose: Inject 90mg SC every 8 weeks beginning 8 weeks after intital dose	☐ 1 syringe	
☐ Xeljanz®	☐ 5mg tablets ☐ 10mg tablets ☐ 11mg XR tablets	Immediate release: Initial Dose: 10mg orally twice daily (maximum of 16 weeks) Maintenance Dose: 5mg orally twice daily	60	
		Extended release: Initial Dose: 22mg orally once daily (maximum of 16 weeks) Maintenance Dose: 11mg orally once daily	30	
☐ Xifaxan®	☐ 550mg tablets	Directions: _____	60	
☐ Zeposia®	☐ 7 Day Starter ☐ 0.92mg capsule	☐ Take one 0.23mg capsule daily for 4 days, then one 0.46mg capsule for 3 days ☐ Take one capsule by mouth daily ☐ Other:_____	☐ Starter Pack ☐ 0.92mg/30 capsules	

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.