Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

ORAL ONCOLOGY (A-N)

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: _____
Insured: _____
Phone: _____
Policy #: _____ Group #: _____

Secondary Insurance: _____
Insured: _____
Phone: _____
Policy #: _____ Group #: _____

ICD-10

ICD-10 Code:	Diagnosis:

Prescription Information

☐ Afinitor® (Everolimus)
☐ Alecensa® (Alectinib HCl)
☐ Alunbrig® (Brigatinib)
☐ Ayvakit™ (Avapritinib)
☐ Balversa® (Erdafitinib)
☐ Bosulif® (Bosutinib)
☐ Braftovi® (Encorafenib)
☐ Brukinsa™ (Zanubrutinib)
☐ Bynfezia Pen™ (Octreotide Acetate)
☐ Cabometyx® (Cabozantinib S-Malate)
☐ Calquence® (Acalabrutinib)
☐ Cometriq® (Cabozantinib S-Malate)
☐ Copiktra® (Duvelisib)
☐ Cotellic® (Cobimetinib)
☐ Cyclophosphamide
☐ Daurismo™ (Glasdegib)
☐ Doptelet® (Avatrombopag)
☐ Erivedge® (Vismodegib)
☐ Erleada® (Apalutamide)
☐ Farydak® (Panobinostat)
☐ Fotivda® (Tivozanib)
☐ Gavreto™ (Pralsetinib)
☐ Gleevec® (Imatinib)
☐ Gleostine® (Lomustine)
☐ Hycamtin® (Topotecan)
☐ Ibrance® (Palbociclib)
☐ Iclusig® (Ponatinib)
☐ Idhifa® (Enasidenib)
☐ Imbruvica® (Ibrutinib)
☐ Inlyta® (Axitinib)
☐ Inqovi® (Decitabine & Cedazuridine)
☐ Inrebic® (Fedratinib)
☐ Iressa® (Gefitinib)
☐ Jakafi® (Ruxolitinib)
☐ Kisqali® (Ribociclib)
☐ Koselugo™ (Selumetinib)
☐ Lenvima® (Lenvatinib)
☐ Lonsurf® (Trifluridine-Tipiracil)
☐ Lorbrena® (Lorlatinib)
☐ Lumakras™ (Sotorasib)
☐ Lynparza® (Olaparib)
☐ Mekinist® (Trametinib)
☐ Mektovi® (Binimetinib)
☐ Nerlynx® (Neratinib)
☐ Nexavar® (Sorafenib)
☐ Nilandron® (Nilutamide)
☐ Ninlaro® (Ixazomib)
☐ Nubeqa™ (Darolutamide)

Dose/ Strength	Directions	Quantity	Refills

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: 08/16/21