Home Infusion & Specialty Pharmacy
CHARTWELL SM

Supprelin® LA, Lupron Depot-Ped®, Testosterone Referral Form

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

Patient Information

Date: _____ Patient SS#: _____ ☐ Male ☐ Female

Patient's First Name: _____ Patient's Last Name: _____

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

Phone #: _____ Alternate Phone #: _____

DOB: _____ Wt: _____ Ht: _____ Caregiver/Emergency Contact: _____ Phone #: _____

Allergies: _____ Latex: ☐ Yes ☐ No

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Insured: _____ Insured: _____

Phone: _____ Phone: _____

Policy #: _____ Grp #: _____ Policy #: _____ Grp #: _____

ICD10

Diagnosis: ☐ E23.6 Hypogonadotropic ☐ E29.1 Hypogonadism Male

☐ E30.1 Precocious sexual development & puberty ☐ Other: _____

Prescription

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Supprelin® LA	☐ 50mg implant	Surgically insert subcutaneously into upper extremity	☐ One	
☐ Lupron Depot-Pediatric®	☐ 7.5mg prefilled syringe ☐ 11.25mg prefilled syringe ☐ 15mg prefilled syringe	Inject _____mg IM every ____ days	☐ _____	
☐ Testosterone cypionate	☐ _____ mg	Inject IM every _____ weeks	☐ _____	

Prescriber Information

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

Ship to Other: _____

Physician's Name (please print): _____

Office Contact Name: _____

Phone #: _____ Fax #: _____ DEA #: _____

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

Physician's Signature: _____

I authorize Chartwell Pennsylvania Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

updated 2.22.16

FAX: (412) 920-1869 PHONE: (800) 366-6020