CHARTWELL Home Infusion & Specialty Pharmacy
PENNSYLVANIA, LP

Women's Health

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

☐ N80.0 Endometriosis of uterus
☐ N80.1 Endometriosis of ovary
☐ N80.2 Endometriosis of fallopian tube
☐ N80.3 Endometriosis of pelvic peritoneum
☐ N60.4 Endometriosis of rectovaginal septum & vagina
☐ N80.5 Endometriosis of intestines
☐ N80.6 Endometriosis in scar of skin
☐ N80.8 Endometriosis of other unspecified sites
☐ N80.9 Endometriosis site unspecified
☐ D25.9 Uterine leiomyoma, unspecified

☐ Other:

Prescription Information

Medication	Dose/ Strength	Directions	Quantity	Refills
☐ Hydroxyprogesterone Caporate Injection	☐ 250mg/mL 1mL SDV	☐ Inject 1mL each week (every 7 days)	☐ 1 month supply	
☐ Lupeneta Pack™	☐ 11.25mg and 5mg Pack ☐ 3.75mg and 5mg Pack	Use as directed on pack	☐ 1 month supply	
☐ Lupron Depot®	☐ 3 Month, Inject 11.25mg ☐ 3.75mg	☐ Inject IM every 3 months ☐ Inject IM every 1 month	☐ 1 month supply	
☐ Makena® (Hydroxyprogesterone Caporate Injection)	☐ 275mg/ 1.1mL Autoinjector	☐ Inject 1.1 mL each week (every 7 days)	☐ 1 month supply	
☐ Myfembree®	relugolix 40mg, estradiol 1mg, and norethindrone acetate 0.5mg tablets	Take 1 tablet once daily		
☐ Orilissa®	☐ 150mg tablets ☐ 200mg tablets	☐ Take 1 tablet once daily ☐ Take 1 tablet twice a day		
☐ Zoladex®	☐ 3.6mg, 1-month	☐ Inject 3.6mg SC every 1 month	☐ 1 month supply	

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: 06/22/21