Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

UROLOGY

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

☐ C61 Malignant Neoplasm of Prostate	☐ Carcinoma in situ (CIS) of unirnary bladder	☐ Primary or recurrent papillary tumor (Ta or T1)	☐ Other:

Prescription Information

Medication	Dose/ Strength	Directions	Quantity	Refills
☐ Eligard®	☐ 7.5mg - 1 month - Inject 7.5mg SC every 1 month ☐ 22.5mg - 3 month - Inject 22.5mg SC every 3 months ☐ 30mg - 4 month - Inject 30mg SC every 4 months ☐ 45mg - 6 month - Inject 45mg SC every 6 months		☐ 1 (one)	
☐ Firmagon®	☐ 120mg/ vial treatment pack (2 vials) - Inject 240mg SC as two injections of 120mg each		☐ 1 (one)	
	☐ 80mg/vial - Inject 80 mg SC every 28 days		☐ 1 (one)	
☐ Lupron Depot®	☐ 7.5mg - Inject 7.5mg IM every 28 days ☐ 3 Month, 22.5mg - Inject 22.5mg IM every 3 months ☐ 4 Month, 30 mg - Inject 30 mg IM every 4 months ☐ 6 Month, 45 mg - Inject 45 mg IM every 6 months			
☐ TheraCys®	☐ 81mg	☐ Treatment: instill 1 vial (81mg) intravesically once weekly.	☐ Six Weeks ☐ Other: _____Weeks	
		☐ Treatment: instill 1 vial (81mg) intravesically _____.	☐ Other: _____Weeks	
☐ TICE® BCG	☐ 50mg vial lyophilized powder	☐ Treatment: instill 1 vial (50mg) intravesically once weekly.	☐ Six Weeks ☐ Other: _____Weeks	
		☐ Other: instill 1 vial (50mg) intravesically _____.	☐ Other: _____Weeks	
☐ Vantas	☐ 50mg implant	Surgically inserted by provider every 12 months	1 (one)	
☐ Zoladex®	☐ 3.6mg, 1-month - Inject 3.6mg SC every 1 month ☐ 10.8mg, 3 month - Inject 10.8mg SC every 3 months		☐ 1 (one)	

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: 07/16/20