



Supprellin[®] LA Lupron Depot-Ped[®] Referral Form

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

Patient Information	Date: _____ Patient SS#: _____ <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No

Insurance Information	Primary Insurance: _____ Secondary Insurance: _____
	Insured: _____ Insured: _____
	Phone: _____ Phone: _____
	Policy #: _____ Grp #: _____ Policy #: _____ Grp #: _____

ICD9	Diagnosis: <input type="checkbox"/> 259.1 Precocious sexual development & puberty <input type="checkbox"/> Other: _____
------	---

Prescription	Medication	Dose/Strength	Directions	Quantity	Refills
	<input type="checkbox"/> Supprellin [®] LA	<input type="checkbox"/> 50mg implant	Surgically insert subcutaneously into upper extremity	<input type="checkbox"/> One	
<input type="checkbox"/> Lupron Depot-Ped [®]	<input type="checkbox"/> 7.5mg prefilled syringe <input type="checkbox"/> 11.25mg prefilled syringe <input type="checkbox"/> 15mg prefilled syringe	Inject _____ mg IM every ____ days			

Prescriber Information	Date Shipment Needed: _____ Ship to: _____ Patient _____ Physician/Clinic
	Ship to Other: _____
	Physician's Name (please print): _____
	Office Contact Name: _____
	Phone #: _____ Fax #: _____
	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.

PHONE: (800) 755-4704

FAX: (412) 920-1869