



Boniva[®], Reclast[®], Forteo[®], Prolia[®] 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: _____ 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"/> 733.00 Generalized Osteoporosis <input type="checkbox"/> 733.01 Postmenopausal Osteoporosis <input type="checkbox"/> 733.02 Idiopathic Osteoporosis
	<input type="checkbox"/> 733.09 NEC Osteoporosis <input type="checkbox"/> Other: _____

Prescription	Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/>	Boniva [®]	3mg/3ml PFS Kit	Infuse 3mg IV Push every 3 months	3 month supply	
<input type="checkbox"/>	Reclast [®]	5mg/100ml	Infuse 5mg IV over 15-20 minutes annually	1	0
<input type="checkbox"/>	Forteo [®]	600mcg/2.4 ml pen <input type="checkbox"/> 32ga <input type="checkbox"/> 30/31 ga <input type="checkbox"/> 29ga	Inject 20mcg/0.8ml SC once daily	30 day supply	
<input type="checkbox"/>	Prolia [®]	<input type="checkbox"/> 60mg/1ml PFS <input type="checkbox"/> 60mg/1ml single use vial	Inject 60mg/1ml SC every 6 months	1	

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