



# Lupron Depot<sup>®</sup>, Eligard<sup>®</sup>, Zoladex<sup>®</sup> Referral Form

Auth #: \_\_\_\_\_ Auth Dates: \_\_\_\_\_  UPMC prior Auth form attached

<b>Patient Information</b>	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

<b>Insurance Information</b>	Primary Insurance: _____ Secondary Insurance: _____
	Insured: _____ Insured: _____
	Phone: _____ Phone: _____
	Policy #: _____ Grp #: _____ Policy #: _____ Grp #: _____

<b>ICD9</b>	Diagnosis: <input type="checkbox"/> 185 Malignant Neoplasm of Prostate <input type="checkbox"/> Other
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<b>Prescription</b>	Medication	Dose/Strength & Directions	Quantity	Refills
	<input type="checkbox"/> Lupron Depot <sup>®</sup>	<input type="checkbox"/> 4 Month, 30 mg - Inject 30 mg IM every 4 months <input type="checkbox"/> 3 Month, 22.5mg - Inject 22.5mg IM every 3 months <input type="checkbox"/> 7.5mg - Inject 7.5mg IM every _____ months	1 (one)	
	<input type="checkbox"/> Eligard <sup>®</sup>	<input type="checkbox"/> 7.5mg - 1 month - Inject 7.5mg SC every 1 month <input type="checkbox"/> 22.5mg - 3 month - Inject 22.5mg SC every 3 months <input type="checkbox"/> 30mg - 4 month - Inject 30mg SC every 4 months <input type="checkbox"/> 45mg - 6 month - Inject 45mg SC every 6 months	1 (one)	
	<input type="checkbox"/> Zoladex <sup>®</sup>	<input type="checkbox"/> 3.6mg, 1-month - Inject 3.6mg SC every 1 month <input type="checkbox"/> 10.8mg, 3 month - Inject 10.8mg SC every 3 months	1 (one)	

<b>Prescriber Information</b>	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**