Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

Toxin Referral Form

Auth #: _____ **Auth Dates:** _____ ☐ **UPMC prior auth form attached**

Patient Information

Date: _____ Patient SS#: _____ DOB: _____ ☐ Male ☐ Female

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Alternate Phone #: _____

Caregiver/ Emergency Contact: _____ Phone #: _____

Weight:_____ Allergies: _____ Latex allergy: ☐ Yes ☐ No

Insurance

Primary Insurance: _____

Insured: _____

Phone: _____

Policy: _____ Grp #: _____

Secondary Insurance: _____

Insured: _____

Phone: _____

Policy: _____ Grp #: _____

ICD10

Diagnosis:

☐ G24.3 Spasmodic torticollis
☐ G24.8 Dystonia
☐ G43.719 Chronic migraine
☐ G24.5 Blepharospasm
☐ G81.11 Spastic Hemiplegia affecting right dominant side
☐ G81.12 Spastic Hemiplegia affecting left dominant side
☐ 780.8 Hyperhidrosis
☐ Other: _____

Prescription

Medication	Dose/ Strength	Directions	Quantity	Refills
☐ **Botox®**	☐ 100 units/vial ☐ 200 units/vial	☐ Inject _____units as directed to the affected areas in one session	____ vials	
☐ **Dysport®**	☐ 300 units/vial ☐ 500 units/vial	☐ Inject _____units as directed to the affected areas in one session	____ vials	
☐ **Myobloc®**	☐ 2,500 units/0.5ml ☐ 5,000 units/1ml ☐ 10,000 units/2ml	☐ Inject _____units as directed to the affected areas in one session	____ vials	
☐ **Xeomin®**	☐ 100 units/vial	☐ Inject _____units as directed to the affected areas in one session	____ vials	

Prescriber Information

Date Shipment Needed: _____ Ship to: ☐ Patient ☐ Physician/ Clinic

☐ Ship to other: _____

Physician's Name: _____ Office Contact Name: _____
(please print)

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: 10/10/18

PHONE: (800) 366-6020 FAX: (412) 920-1869