Home Infusion & Specialty Pharmacy
CHARTWELL℠

# Lupron Depot®, Zoladex® Referral Form

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

## Patient Information

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

Patient's First Name: _____ Patient's Last Name: _____

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

Phone #: _____ Alternate Phone #: _____

DOB: _____ Wt: _____ Caregiver/Emergency Contact: _____ Phone #: _____

Allergies: _____ Latex: ☐ Yes ☐ No

## Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Insured: _____ Insured: _____

Phone: _____ Phone: _____

Policy #: _____ Grp #: _____ Policy #: _____ Grp #: _____

## ICD10

**Diagnosis:**

| | |
|---|---|
| ☐ N80.0 Endometriosis of uterus | ☐ N80.5 Endometriosis of intestines |
| ☐ N80.1 Endometriosis of ovary | ☐ N80.6 Endometriosis in scar of skin |
| ☐ N80.2 Endometriosis of fallopian tube | ☐ N80.8 Endometriosis of other unspecified sites |
| ☐ N80.3 Endometriosis of pelvic peritoneum | ☐ N80.9 Endometriosis site unspecified |
| ☐ N60.4 Endometriosis of rectovagional septum & vagina | ☐ D25.9 Uterine leiomyoma, unspecified |
| ☐ Other _____ | |

## Prescription

| Medication | Dose/Strength & Directions | Quantity | Refills |
|---|---|---|---|
| ☐ Lupron Depot® | ☐ 3 Month, Inject 11.25mg IM every 3 months<br>☐ 3.75mg - Inject IM every 1 month | 1 (one) | |
| ☐ Zoladex® | ☐ 3.6mg, 1-month - Inject 3.6mg SC every 1 month | 1 (one) | |

## 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.

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

updated 2/22/16