Home Infusion & Specialty Pharmacy
CHARTWELL℠

BCG
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: ☐ Carcinoma in situ (CIS) of unirnary bladder ☐ Primary or recurrent papillary tumor (Ta or T1)

☐ Other: _____

Prescription

Medication	Dose/Strength	Directions	Duration	Refills
☐ TICE® BCG	☐ 50mg vial lyophilized powder	☐ Treatment: instill 1 vial (50mg) intravesically once weekly.	☐ Six Weeks ☐ Other: _____Weeks	
		☐ Other: instill 1 vial (50mg) intravesically _____.	☐ Other: _____Weeks	
☐ TheraCys®	☐ 81mg	☐ Treatment: instill 1 vial (81mg) intravesically once weekly.	☐ Six Weeks ☐ Other: _____Weeks	
		☐ Treatment: instill 1 vial (81mg) intravesically _____.	☐ Other: _____Weeks	

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.

updated 2/17/16

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