

**CYSTIC FIBROSIS
ENROLLMENT / PRESCRIPTION FORM**

Customer Service Phone 1-800-850-9122

Fax to 1-800-218-3221

PATIENT INFORMATION

Last Name	First Name	MI	ID Number
Home Address	City	State	Zip
Parent or Guardian Name			Home Phone Number ()
Shipping Address(if different from home address) <input type="checkbox"/> Ship to MD			Work Phone Number ()

INSURANCE INFORMATION (fill out entirely or fax a copy of patient's Insurance card, both sides)

Primary Insurance	Secondary Insurance
Insured	Insured
Policy Number	Policy Number
Group Number	Group Number
Phone Number	Phone Number

PRIMARY DIAGNOSIS

ICD-9	Diagnosis
277.0	Cystic Fibrosis
277.02	Cystic Fibrosis with pulmonary manifestations
	Other Specify

MEDICAL INFORMATION

Allergies _____ NKDA
 Co-morbidities _____ See Attached
 Current Medications _____ See Attached

PRESCRIPTION INFORMATION

Pulmozyme 2.5mg/2.5mL Ampule	TOBI 300mg/5mL Ampule
Directions:	Directions:
Qty _____ Refill x _____ doses	Qty _____ Refill x _____ doses

PRESCRIBER INFORMATION

Prescriber	Specialty	Office Contact	Phone Number
Address	City	State	Zip
Today's Date	Date Needed	I certify that the above therapy is medically necessary and all the above information is accurate to the best of my knowledge.	
Physician's Signature: _____		NPI _____	DEA _____

Refrigerated prescriptions are shipped Mon. - Thurs. via standard overnight service. Saturday delivery requires approval from an Ascend pharmacist. For refills, please call-in or fax 7 days in advance of next appointment.

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