

**GAUCHER'S DISEASE  
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
Shipping Address (if different from home address) <input type="checkbox"/> Ship to MD		Home Phone Number ( ) ( )	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
	Lipidoses (Gaucher's Disease)
	Other Specify

**MEDICAL INFORMATION**

Date of diagnosis \_\_\_\_\_ Height \_\_\_\_\_  in  cm Weight \_\_\_\_\_  lbs  kg  
Hgb \_\_\_\_\_ HCT \_\_\_\_\_ WBC \_\_\_\_\_ ALT \_\_\_\_\_ PLTS \_\_\_\_\_ Acid Phosphaetes \_\_\_\_\_  
Allergies \_\_\_\_\_  NKDA  
Name of medication Previously tried \_\_\_\_\_ Length of Treatment \_\_\_\_\_  See Attached  
Reason for discontinuation \_\_\_\_\_  See Attached  
Co-morbidities \_\_\_\_\_  See Attached  
Current Medications \_\_\_\_\_  See Attached

**PRESCRIPTION INFORMATION**

Cerezyme (imiglucerase)	Other
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 _____	Fax Number 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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