



GROWTH HORMONE (ADULT) 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

PRIMARY DIAGNOSIS

ICD-9	Diagnosis
253.2	Panhypopituitarism
253.3	Pituitary Dwarfism (isolated deficiency of human growth hormone)
253.7	Latrogenic Pituitary Disorder (hormone-, hypophysectomy-, postabiative radiotherapy-induced)
253.0	Disorders of the pituitary gland and its hypothalamic control
253.8	Other disorders of the pituitary and other syndromes of diencephalohypophysial origin
194.3	Craniopharyngioma
	Cachexia / Aids Wasting (Serostim)
	Other specify

MEDICAL INFORMATION

Provocative Test Agent	Peak Value	Test Date	IGF-1	
Provocative Test Agent	Peak Value	Test Date	IGFBP-3	
Other Test	Date Tx Initiated	Estimated Tx Duration	Date of Last Visit	
Notes				

PRESCRIPTION INFORMATION

Drug Name	Dose in mg	Frequency	
Diluent/ Volume	Supplies	Refills	
This is an initial certification	This is a re-certification	Authorization is valid for	12 months

PRESCRIBER INFORMATION

Prescriber	Specialty	Office Contact	Phone Number
Address			Fax Number
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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