Ascend SpecialtyRx®
Simplifying Care. Achieving Outcomes.

GROWTH HORMONE *(CHILD)*
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	Date of Birth
Parent or Guardian Name			Home Phone Number ( )
Shipping Address(if different from home address)		☐ 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	Iatrogenic 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
	783.43	Lack of expected normal physiological development in childhood/ short stature
	758.6	Turner's Syndrome (gonadal dysgenesis)
		Other condition, including: Russell-Silver, Noonan, Prader-Willi syndromes **Specify**

MEDICAL INFORMATION

Height & %ile		Weight & %ile		Date Measured		Growth Velocity	
Bone Age		Actual Age		Date Measured		Open Epiphyses?	
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	City	State / Zip	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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