GROWTH HORMONE (Renal)
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**
	585.0	Chronic renal failure, chronic uremia
	582.0 -.9	Chronic glomerulonephritis
	583.0 -.9	Nephritis and nephropathy
	753.0 -.9	Congenital anomalies of urinary system
	593.0 -.9	Other disorders of the kidney and ureter
	783.4	Lack of expected normal physiological development in chilhood / short staure
		Other Specify
		Other Specify

MEDICAL INFORMATION

Height & %ile		Weight & %ile		Date Measured		Growth Velocity	
Bone Age		Actual Age		Date Measured		Open Epiphyses?	
Other Test and Date		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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