

PATIENT INFORMATION

Last Name	First Name	MI	ID Number
Home Address	City	State	Zip
Date of Birth / /			
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
Policy Number	Policy Number
Group Number	Group Number

MEDICAL INFORMATION

Diagnosis :
 Mucopolysaccharidosis I (MPS I) Pompe Disease Fabry Disease Gaucher Disease – Type 1 2 3 Other _____

Date of Diagnosis _____ Start Date _____ Review Date (within 6 months of start date) _____

Weight _____ lbs kg Allergies _____ NKDA

Anemia Bone Disease Thrombocytopenia Hepatomegaly/ Splenomegaly Ophthalmoplegia Other _____ See Attached

Hgb _____ HCT _____ WBC _____ PLTS _____ ALT _____ Glucerebrosidase activity _____ %

Current Medications _____ See Attached

If previously treated; medications used and reason for discontinuation : _____

PRESCRIPTION INFORMATION

<input type="checkbox"/> Cerezyme <input type="checkbox"/> 200 unit vial or <input type="checkbox"/> 400 unit vial	<input type="checkbox"/> Fabrazyme <input type="checkbox"/> 5mg vial or <input type="checkbox"/> 35mg vial
<input type="checkbox"/> _____ units/kg Body Weight IV every _____ days	<input type="checkbox"/> _____ units/kg Body Weight IV every _____ days
Quantity: _____ doses Refill x: _____	Quantity: _____ doses Refill x: _____
<input type="checkbox"/> Myozyme 50mg vial	<input type="checkbox"/> Aldurazyme 2.9mg vial
<input type="checkbox"/> _____ units/kg Body Weight IV every _____ days	<input type="checkbox"/> _____ units/kg Body Weight IV every _____ days
Quantity: _____ doses Refill x: _____	Quantity: _____ doses Refill x: _____

PRESCRIBER INFORMATION

Prescriber Name	Specialty	Office Contact	Phone Number
Address			Fax Number
City	State	Zip	
Today's Date / /	Date Needed By / /	DEA <input type="checkbox"/> On File	NPI <input type="checkbox"/> On File

I certify that the above therapy is medically necessary and all the above information is accurate to the best of my knowledge.

Prescriber's Signature _____

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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