CYSTIC FIBROSIS ENROLLMENT/PRESCRIPTION FORM

Customer Service Phone 1-800-850-9122

Fax 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**
Policy Number	Policy Number
Group Number	Group Number

MEDICAL INFORMATION

Diagnosis: Cystic Fibrosis (277.0) Cystic Fibrosis with Pulmonary Manifestations (277.02)

Other________________________ Date of Diagnosis____________ See Attached

Start Date_________________________ Review Date (within 6 months of start date) ________________________

Height__________ In Kg Weight__________ Lbs Kg Date of Measurement______________ See Attached

Current Medications____ See Attached

Allergies____ NKDA

Co-Morbiditis____ See Attached

PRESCRIPTION INFORMATION

Pulmozyme 2.5mg/2.5ml Ampule	**TOBI 300mg/5ml Ampule**
Directions: **Qty**________ **Refill x**______	**Directions**: **Qty**________ **Refill x**______

Other

Directions:

Qty________ **Refill x**______

PRESCRIBER INFORMATION

Prescriber Name	Specialty	Office Contact	Phone Number ( )
Address	City, State	Zip	Fax Number ( )
Today's Date	Date Needed By	DEA On File	NPI 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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