Ascend SpecialtyRx®
Simplifying Care. Achieving Outcomes.

INJECTABLE ONCOLOGY
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
Shipping Address (if different from home address) ☐ 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
Insured	Insured
Policy Number	Policy Number
Group Number	Group Number

PRIMARY DIAGNOSIS

ICD-9	Diagnosis
	Other specify

MEDICAL INFORMATION

Start Date____________________ End Date ____________________ Next Chemotherapy Cycle____________________

Height ______________ ☐ cm ☐ in Weight ______________ ☐ kg ☐ lbs Date of Last measurement ________________

Allergies ____ ☐ NKDA

Co-morbidities ____ ☐ See Attached

Current Medications ________+____ ☐ See Attached

PRESCRIPTION INFORMATION

___ **Alferon N**	___ **Faslodex**
☐ BNMN/DAW	☐ BNMN/DAW
Sig:____________________________________	Sig:____________________________________
Qty ______________ Refill x ______________ months	Qty ______________ Refill x ______________ months
___ **Intron A**	___ **Lupron** ___ **Lupron Depot**
☐ BNMN/DAW	☐ BNMN/DAW
Sig:____________________________________	Sig:____________________________________
Qty ______________ Refill x ______________ months	Qty ______________ Refill x ______________ months
___ **Sandostatin** ___ **Sandostatin LAR**	___ **Viadur**
☐ BNMN/DAW	☐ BNMN/DAW
Sig:____________________________________	Sig:____________________________________
Qty ______________ Refill x ______________ months	Qty ______________ Refill x ______________ months
___ **Zoladex**	___ **Other**
☐ BNMN/DAW	☐ BNMN/DAW
Sig:____________________________________	Sig:____________________________________
Qty ______________ Refill x ______________ months	Qty ______________ Refill x ______________ 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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