

\*Required field.

**PATIENT ENROLLMENT FORM**

**Patient support services requested:**

YUWIWEL FastStart  Injection training support  Ascendis Patient Assistance Program  A-S-A-P Bridge Support

1-PATIENT INFORMATION	Patient name*: _____	Parent/Guardian #1:	Parent/Guardian #2:
	Date of birth*: __/__/____ Sex*: <input type="checkbox"/> M <input type="checkbox"/> F	Name*: _____	Name: _____
	Address*: _____	Relationship to patient*: _____	Relationship to patient: _____
	City*: _____ State*: ____ ZIP*: _____	Phone*: (____) ____-____	Phone: (____) ____-____
	Primary language: _____	Email: _____	Email: _____

2-INSURANCE	<input type="checkbox"/> Copies of front and back of primary medical insurance and pharmacy insurance (if applicable) cards are attached		Prior authorization (PA) submitted: <input type="checkbox"/> Yes <input type="checkbox"/> No PA approval: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of PA approval: __/__/____ Reference number: _____
	<input type="checkbox"/> Patient has pharmacy insurance <input type="checkbox"/> Patient is not insured		
	Primary medical insurance*: _____		
	Pharmacy/Rx insurance: _____		
	Member ID #*: _____ Group ID #: _____	Member name: _____	

3-DIAGNOSIS	<input type="checkbox"/> <b>Please check box to confirm ICD-10 diagnosis: Q77.4 Achondroplasia*</b>
	ICD-10 CM Q77.4 is used for achondroplasia; YUWIWEL is only indicated for increasing linear growth in pediatric patients with achondroplasia and open growth plates (epiphyses).

4-MEDICAL ASSESSMENT	<b>Please provide the following details:</b>		Confirmed FGFR3 mutation Date of test: __/__/____ Open epiphyses*: <input type="checkbox"/> Yes <input type="checkbox"/> No X-ray date: __/__/____
	Current weight*: _____ kg	Known drug allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Date of measure*: __/__/____	If yes, list allergies*: _____	
	Height: _____ cm	Concurrent medications*: _____	
	Date of measure: __/__/____		

5-PRESCRIBER INFORMATION	Prescriber name*: _____	Address*: _____	Office contact*: _____
	Practice*: _____	City*: _____ State*: _____	Office contact phone*: (____) ____-____
	DEA #: _____	ZIP*: _____	Office contact fax*: (____) ____-____
	Prescriber NPI #*: _____		Office contact email*: _____

6-PRESCRIPTION/ DOSAGE	<b>YUWIWEL weekly subcutaneous dose and injection volume (please select the weekly dose/injection volume based on the patient's body weight)*:</b>		
	<b>1.3 mg vial (NDC 73362-201-01)</b>	<b>2.8 mg vial (NDC 73362-202-01)</b>	<b>5.5 mg vial (NDC 73362-203-01)</b>
	<input type="checkbox"/> <b>8.0 to 9.9 kg</b> ; 0.88 mg (0.40 mL) SC weekly	<input type="checkbox"/> <b>13.5 to 17.5 kg</b> ; 1.6 mg (0.35 mL) SC weekly	<input type="checkbox"/> <b>30.6 to 41.2 kg</b> ; 3.6 mg (0.65 mL) SC weekly
	<input type="checkbox"/> <b>10.0 to 13.4 kg</b> ; 1.2 mg (0.55 mL) SC weekly	<input type="checkbox"/> <b>17.6 to 23.0 kg</b> ; 2.1 mg (0.45 mL) SC weekly	<input type="checkbox"/> <b>41.3 to 55.9 kg</b> ; 5.0 mg (0.90 mL) SC weekly
		<input type="checkbox"/> <b>23.1 to 30.5 kg</b> ; 2.8 mg (0.60 mL) SC weekly	<input type="checkbox"/> <b>56.0 to 73.5 kg</b> ; 6.6 mg (2 x 0.60 mL) SC weekly
		<input type="checkbox"/> <b>73.6 to 90.0 kg</b> ; 8.8 mg (2 x 0.80 mL) SC weekly	
Month(s) supply: _____	Refills: _____		

7-PRESCRIBER AUTHORIZATION	I certify that the information provided above is, to the best of my knowledge current, complete, and accurate and the therapy I have prescribed above is medically necessary for this patient and patient's records contain supporting documentation that substantiates the utilization and medical necessity of the therapy. I have discussed A-S-A-P with my patient and my patient would like to be screened for eligibility for A-S-A-P and provided, if applicable, any services under A-S-A-P. I will comply with my own state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language. I understand that noncompliance with state-specific requirements could result in outreach to the prescriber. I authorize the provision to patient of ancillary supplies, such as sharps containers and alcohol swabs, to administer the therapy. I acknowledge that the prescription may only be filled by a limited number of specialty pharmacies and prescriber authorizes Ascendis and those acting on its behalf to transmit the prescription electronically, by facsimile, or by mail to the appropriate dispensing specialty pharmacy.	
	<input type="checkbox"/> Dispense as written	<input type="checkbox"/> Substitution allowed
	Prescriber signature*: _____ Date: __/__/____	Prescriber signature*: _____ Date: __/__/____

8-TRAINING SUPPORT AUTHORIZATION	Injection Training Support Authorization A-S-A-P will provide my patient/patient's caregiver with training on the proper administration of YUWIWEL. I am requesting A-S-A-P to coordinate YUWIWEL injection training support for my patient/patient's caregiver. I will receive information on the injection training support that my patient/patient's caregiver has received via the fax number I provided above. This order is valid for 1 year.
	<input type="checkbox"/> <b>I do not wish to have my patient/patient caregiver trained by A-S-A-P.</b> By checking this box and opting out of injection training support, I acknowledge that I will assume responsibility and arrangements for YUWIWEL injection training for this patient/patient caregiver.

YUWIWEL will be dispensed solely through AnovoRx.  
FGFR3 = fibroblast growth factor receptor-3; SC = subcutaneous.  
\*This form cannot be processed without prescriber's signature.