

Patient Information

Patient Name (First and Last) _____ Date of Birth (DOB) _____
 Parent/Guardian Name _____ Relationship to Patient _____
 Address _____ City _____ State _____ ZIP _____
 Home Phone _____ Work Phone _____ Social Security Number _____
 Allergies None Other _____ Gender M F Primary Language _____
 Referring Physician _____ Specialty _____

Insurance Information/ Attach Copy of Insurance Card

Physician Provider/Tax ID # _____
 Primary Insurance _____ Insurance Company Phone _____
 Subscriber _____ DOB _____ Subscriber ID # _____
 Policy/Employer/Group # _____
 Secondary Insurance _____ Insurance Company Phone _____
 Subscriber _____ DOB _____ Subscriber ID # _____
 Policy/Employer/Group # _____

Diagnosis

SGA Recommended ICD-9 Growth Failure (783.43), plus
 Small for Dates (764.00), or Intrauterine Growth Retardation, Unspecified (764.90)
 Isolated Growth Hormone Deficiency (253.3)
 Iatrogenic Hypopituitarism (253.7): hypophysectomy-induced, postablative, or radiotherapy-induced
 Panhypopituitarism (253.2) Prader-Willi Syndrome (759.81) Turner Syndrome (758.6) Other (specify by ICD-9 Code) _____

Medical Assessment FAX or MAIL Growth Chart With SMN (Required)

Current Height _____ cm _____% Current Weight _____ kg _____% Gestational Age _____ Chronologic Age _____ Y _____ M
 Bone Age _____ Y _____ M Skeletal X-Ray Date _____ Growth Velocity _____ cm/y
 If SGA: Birth Weight _____ Birth Length _____ Birth Mother's Height _____ cm Birth Father's Height _____ cm
 Growth Hormone Stimulation Test Date _____ Other Lab Tests _____
 (Not required for SGA or Prader-Willi syndrome)
 Agent 1 _____ Peak _____ Test _____ Result _____
 Agent 2 _____ Peak _____ Test _____ Result _____

Prescription Options for Genotropin

(choose A, B, C, or D, plus choose pen needle or insulin syringe size)

A. Genotropin PEN[®] 5 Growth Hormone Delivery Device 5.8 mg **Genotropin** Pen Needle Gauge _____
 (dose in increments of 0.1 mg) (5 mg/mL)

B. Genotropin PEN[®] 12 Growth Hormone Delivery Device 13.8 mg **Genotropin** Pen Needle Gauge _____
 (dose in increments of 0.2 mg) (12 mg/mL)

C. Genotropin MIXER[®] Growth Hormone Reconstitution Device 5.8 mg **Genotropin** Insulin Syringes 0.3 mL 0.5 mL 1.0 mL
 (12 mg/mL) Needle Gauge _____

D. Genotropin MINIQUICK[®] is available in 10 strengths, each in a package of 7. After reconstitution, each strength delivers a fixed volume of 0.25 mL. A 30-gauge, 5/16" injection needle is prepacked with each device. Please select strength.
 0.2 mg 0.4 mg 0.6 mg 0.8 mg 1.0 mg 1.2 mg 1.4 mg 1.6 mg 1.8 mg 2.0 mg

Dose to Be Given Subcutaneously

Daily Dose _____ mg/day Days Supply _____ Refills _____ (months) Start Date _____ Ship Product by _____
 Weekly Dose _____ mg/kg/week Prescription Special Instructions _____

Special Instructions (if applicable)

Preferred Pharmacy _____ Case Management Not Requested
 Other _____ Patient Device Training Requested
 Interim Care Requested

Physician Certification

1) I certify that the treatment listed above is and will be medically necessary based on my best professional judgment, and that the information provided above is complete and accurate to the best of my knowledge. 2) I also certify that I have obtained the written permission of the patient (or the patient's legal representative) to disclose the information here and such other health or personal information to the Pfizer Bridge Program[™] ("the Program"), Pfizer, and/or its agents as may be necessary for the patient's participation in the Program. (A signed copy of a Pfizer Bridge Program[™] Patient Authorization Form ["the Authorization"] either accompanies this completed Statement of Medical Necessity or, to the best of the undersigned's knowledge, is already on file with the Pfizer Bridge Program[™].) I understand that the Program may use and disclose this information only in accordance with the Authorization. 3) I further certify that (a) any service provided through the Pfizer Bridge Program[™] on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use Genotropin[®] or any other Pfizer product or service for anyone, and (b) my decision to prescribe Genotropin was based on my determination of medical necessity as set forth herein.

Signature* _____ Date _____
 Print Name _____ National Provider ID (NPI) _____ DEA # _____
 Address _____ City _____ State _____ ZIP _____
 Office Contact _____ Phone _____ Fax _____

*This form cannot be processed without physician's signature.



Pfizer Bridge Program™ Fax Number: **1-800-479-2562**
Pfizer Bridge Program Phone Number: **1-800-645-1280**

Documentation Required for SMN Submission

Diagnosis	History and physical	Related clinical notes	Growth chart	Growth velocity	Birth wt/ length/ gestational age	Stim test results	IGF-I/ IGF-BP3 report	Bone age X-ray report	Genetic testing report
GHD	✓	✓	✓	✓		✓	✓	✓	
Prader-Willi syndrome	✓	✓	✓						✓
SGA	✓	✓	✓	✓	✓				
Turner syndrome	✓	✓	✓	✓				✓	
