

PATIENT

Name (First and Last): _____ Date of Birth (MM/DD/YY): _____
Patient's Address: _____
City/State/ZIP: _____ Social Security Number: _____ Male Female
Primary Contact: _____ Relationship: _____
Home Ph: () Work Ph: () Cell Ph: () E-Mail: _____

INSURANCE

HMO/EPO PPO POS Medicaid Medicare No Insurance HMO/EPO PPO POS Medicaid Medicare No Insurance
Primary Insurance: See Attached Secondary Insurance: See Attached
Phone: () Phone: ()
Subscriber: Subscriber:
Subscriber ID #: Pol/Grp #: Subscriber ID #: Pol/Grp #:
Employer: Retired Employer: Retired

DIAGNOSIS

Prescription Type: New Start Continued Tx Restart Tx
Isolated Growth Hormone Deficiency (253.3) Panhypopituitarism (253.2)
Iatrogenic-Induced Hypopituitarism (253.7)
Other Disorder Due to Inadequacy of Endogenous Growth Hormone Secretion: _____ Specify by ICD-9: _____

MEDICAL ASSESSMENT

Lab Results: (For Initial Diagnosis Only) See Attached
GH Stimulation Test Date: _____ Baseline IGF-I Level: _____ Weight: _____ Height: _____
Agent: _____ Peak Value: _____ Follow-up IGF-I Level: _____ Total Cholesterol: _____
Is there any evidence of tumor activity or active neoplasm? YES NO HDL: _____ LDL: _____
Clinical Impression: _____
Date Patient Last Seen: _____ Date Therapy Initiated: _____ Estimated Duration: _____

PRESCRIPTION

Injection Training to Be Completed by: Office (by Office Staff) Home (Coordinated by Nutropin® Access Solutions™ or Pharmacy)
Preferred Agency for home injection training: _____ No preferred Agency
Please Dispense: Remember to dispense the corresponding pen if your patient doesn't already have one.
Nutropin AQ Pen 10® Nutropin AQ Pen® 10-mg Cartridge [somatropin (rDNA origin) injection]
Nutropin AQ Pen 20® Nutropin AQ Pen® 20-mg Cartridge [somatropin (rDNA origin) injection]
BD Ultra-Fine™ (original) 29 g/12.7 mm Needles Other Needles
Nutropin AQ® [somatropin (rDNA origin) injection] 10-mg Vial
Nutropin® [somatropin (rDNA origin) for injection] 5 mg 10 mg Dilute: w/ _____ mL
Dispense: _____ Syringes for Inj. ___ 0.3 mL ___ 0.5 mL ___ 1 mL with 30 g/12.7 mm Needles or 31 g/8 mm Needles
Reconstitution Syringes as Needed ___ 1 mL ___ 3 mL ___ 5 mL Other Insulin Syringe: _____
Dose: _____ mg/injection (_____ mL) SubQ: _____ inj./week Dispense: _____ months Refill X _____ or _____ PRN
Starter Rx* Date to Be Shipped: _____ Ship to: _____
*The Starter shipment is a free, one-time, 30-day supply that is not for reselling or billing to any payer.

PRESCRIBER

Prescriber's Full Name: _____ DEA #: _____ Tax ID #: _____
State License #: _____ Exp Date: _____ Prescriber NPI: _____ Group Billing NPI: _____
Address: _____ Prescriber's Medical Specialty: _____
City/State/ZIP: _____ Phone: () Fax: ()
By signing below, I certify that I am prescribing Nutropin therapy for the patient named above and that (a) the above therapy is medically necessary and that I will supervise the patient's treatment accordingly, (b) I am not prescribing Nutropin for any of the following purposes: (1) athletic performance, (2) athletic body building, (3) anti-aging, or (4) cosmetic use, (c) I have received the necessary authorization to release the above referenced information and other protected health information (as defined in the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech USA, Inc., Nutropin Access Solutions and contracted dispensing pharmacy or other contractors for the purpose of seeking reimbursement, assisting in initiating or continuing therapy, including but not limited to the NuAccess Program, and/or the evaluation of the patient's eligibility for the Genentech Access to Care Foundation program related to Genentech products as a break in treatment would negatively impact the patient's therapeutic outcome, (d) I will not sell or bill for any free product received in my office for patients from the Genentech Access to Care Foundation, Starter Programs, or NuAccess Program, and (e) I appoint Nutropin Access Solutions solely to convey on my behalf to the pharmacy chosen by the above-named patient the prescription prescribed herein. I agree to comply with the program guidelines as established by Genentech USA, Inc. and understand that Genentech Access to Care Foundation, at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of the information submitted.
Prescriber's Signature*: _____ Date: _____

INSTRUCTIONS: How to Complete the Statement of Medical Necessity (SMN) Nutropin® and Nutropin AQ® for the Adult Patient

Please write legibly and complete all sections to prevent delays. This instruction sheet may be used for guidance and as a checklist to assist in the completion of the SMN. IT DOES NOT NEED TO BE FAXED WITH THE SMN.

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INSURANCE INFORMATION

- This section should include both primary and secondary insurance including any prescription cards to ensure that ALL potential coverage can be investigated.
- If available, please provide a front and back copy of the insurance card (enlarged and legible) and fax this information with the SMN and PAN.

DIAGNOSIS AND MEDICAL INFORMATION

Diagnosis

- Check the appropriate diagnosis code.
- If "other" is checked, ICD-9 code is required.

The following is a list of what is usually needed by diagnosis (provide on SMN or as a report as appropriate):

Please note that Nutropin® Access Solutions™ may need to request additional information from your office.

Isolated Growth Hormone Deficiency 253.3

- Any History of Head Trauma (if appropriate)
- History and Physical
- DEXA Scan (helpful)
- Lipid Profile (helpful)
- Thyroid Report (helpful)
- Stim Test Result

Iatrogenic-Induced Hypopituitarism 253.7

- MRI
- List of Hormonal Deficiencies and/or Replacements
- History and Physical
- DEXA Scan (helpful)
- Stim Test Result

Panhypopituitarism 253.2

- MRI
- List of Hormonal Deficiencies and/or Replacements
- History and Physical
- DEXA Scan (helpful)
- Lipid Panel (helpful)
- Thyroid Report (helpful)

Date Patient Last Seen/Date Therapy Initiated/Estimated Duration

- Please indicate the date you last saw the patient (date these results are from), the date therapy was originally initiated (or will be initiated) and the estimated duration of therapy (example: lifetime).

PRESCRIPTION

- Please ensure that you complete all areas of the prescription portion correctly and completely.
- A prescription cannot be processed with a stamped signature. The prescriber must sign and date the form to make the prescription valid.
- If you would like a Starter shipment sent to a patient who has never received one, please indicate by checking the box and advising when and where it should be shipped (examples: home or MD office)
(The Starter shipment is a free, one-time, 30-day supply that is not meant for reselling or billing to a payer.)

ATTACH TO COMPLETED SMN

- Any report, demographic sheet or insurance cards that you feel would further your patient's treatment authorization
- If you have one, please attach a signed and dated PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION (PAN) form. This form is needed to fully investigate coverage and to refer the patient to a patient assistance program.
- You may also attach recent visit notes and/or pertinent reports.

REMINDER: The SMN form cannot be fully processed without a prescriber's signature and date, as well as a signed and dated PAN form.