Omnitrope® STATEMENT OF MEDICAL NECESSITY

ASP Access Sandoz Program℠

(somatropin [rDNA origin] for injection) **Omnitrope® Access Sandoz Program** 1620 Century Center Pkwy, Dept. 053, Memphis, TN 38134

Please fill out form completely and **fax back to 877-828-1052** **PHONE: 877-456-6794** **NUMBER OF PAGES IN FAX:** ________

Patient Information

Patient Name ________ Date of Birth (DOB) ________
Parent/Guardian Name ________ Relationship to Patient ________
Address ________ City ________ State ____ ZIP ____
Home Phone ________ Work or Cell Phone ________ Social Security Number ________
Allergies ________ Gender ☐ M ☐ F Primary Language ________
Referring Physician ________ Specialty ________

Insurance Information/ Attach Copy of Insurance Card

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

Adult Diagnosis
- ☐ Isolated Growth Hormone Deficiency (253.3)
- ☐ Iatrogenic Hypopituitarism (253.7)
- ☐ Panhypopituitarism (253.2)

Type of Growth Hormone Deficiency
- ☐ Childhood-Onset
- ☐ Adult-Onset

Pediatric Diagnosis
- ☐ Isolated Growth Hormone Deficiency (253.3)
- ☐ Iatrogenic Hypopituitarism (253.7)
- ☐ Panhypopituitarism (253.2)

Medical Assessment

FAX or MAIL Growth Chart With SMN (Required)

Current Height ____ cm ____ % Current Weight ____ kg ____ Chronologic Age ____ Y ____ M
Bone Age ____ Y ____ M Bone X-Ray Date ________ Growth Velocity ________ cm/y
Birth Mother's Height ____ cm Birth Father's Height ____ cm Predicted Adult Height ____ cm
Growth Hormone Stimulation Test Date ________ Other Lab Tests ________
Agent 1 ________ Peak ________ Test ________ Result ________
Agent 2 ________ Peak ________ Test ________ Result ________

Documentation Attached (For Both Pediatric and Adult Patients)
- ☐ Current History/Physical and Clinical Notes
- ☐ Thyroid Function Test Results ________
- ☐ IGF-I Results ________
- ☐ MRI Results ________

Prescription Options for Omnitrope

- ☐ **Omnitrope® Pen 5** (Growth Hormone Delivery Device) 5 mg Cartridge (5 mg/1.5 mL) (Dose in increments of 0.05 mg)
- ☐ **Omnitrope® Pen 10** (Growth Hormone Delivery Device) 10 mg Cartridge (10 mg/1.5 mL) (Dose in increments of 0.1 mg)
- ☐ **Omnitrope®** 5.8 mg (5 mg/mL)
- ☐ **Ancillary supplies as needed per injection** (i.e., needles, syringes, alcohol wipes)

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)

Pharmacy ________
Other ________

- ☐ Device Training Service
- ☐ Starter Kit
- ☐ Other

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 Access Sandoz Program, Sandoz, and/or its contractors as may be necessary for the patient's participation in the Program. I understand that the Program will use and disclose this information only as necessary to carry out the Program's purposes, 3) I further certify that (a) any service provided through the Access Sandoz 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 Omnitrope or any other Sandoz product or service for anyone, and (b) my decision to prescribe Omnitrope was based solely on my determination of medical necessity as set forth herein, and that (c) I will not seek reimbursement for any medication or service provided by or through the Program from any government program or third party insurer; and 4) I authorize Sandoz and CBS as my designated agents and on behalf of my patient to (a) furnish any information on this form to the insurer of the above-named patient and (b) forward the prescription, by fax or other mode of delivery, to the pharmacy chosen.

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

Prescriber's full **signature.** Actual signature is required – no stamps. Prescriber certifies this is his/her full and usual signature.
Note: TN prescribers – quantity must be written in both numerals and words. Ex: 3 (three) doses.

________ Dispense as Written ________ Substitution Allowed

If NP or PA, under direction of Dr. ________

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

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