

Fax toll-free to  
**877-408-4288**

Please call  
**800-582-7989**  
with any questions.

**Attach**

- Patient Insurance
- Patient Authorization
- Test Results

Register Patient with CFG Only



## Patient Information

Patient (first and last name) \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

Parent/Legal Guardian (first and last name) \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_ E-mail \_\_\_\_\_  
(required)

## Patient Consent and Authorization

In order to participate in EMD Serono's Connections for Growth for Saizen®, I hereby: (1) authorize EMD Serono, Inc., and any third parties working with EMD Serono (collectively, "EMD Serono") to contact my healthcare provider, pharmacy, insurance company, or other third-party payors about my medical, financial, insurance or third-party payor information, including but not limited to any confidential medical information, if applicable (my "Information"), and to use and disclose that Information; and, (2) authorize those parties to disclose (i.e., release) all such Information to EMD Serono. This authorization is permanent unless I notify EMD Serono in writing that I withdraw it.

I understand that in order to participate in EMD Serono's program, I also need to sign a separate "Patient Authorization" form concerning the use and disclosure of my Information and I agree to sign that form. I understand that my prescribing physician is responsible for choosing which prescription products are right for me based on my particular diagnosis.

X \_\_\_\_\_ SS Number \_\_\_\_\_ Date \_\_\_\_\_  
(Patient or Legal Guardian Signature) (Patient or Legal Guardian)

## Insurance Information (Attach copy, front and back, of patient insurance card.)

Primary Insurance \_\_\_\_\_ Phone # \_\_\_\_\_

Cardholder Name \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

## Diagnosis

<input type="checkbox"/> Isolated Growth Hormone Deficiency	ICD-9-CM 253.3	<input type="checkbox"/> Iatrogenic-induced Hypopituitarism	ICD-9-CM 253.7
<input type="checkbox"/> Panhypopituitarism	253.2	<input type="checkbox"/> Other _____	_____

Has patient previously received growth-hormone therapy?  Yes  No

If "Yes," Name of Therapy \_\_\_\_\_

Duration \_\_\_\_\_ Last Dose \_\_\_\_\_

## Medical Assessment

Test Results attached

Chronological Age \_\_\_\_\_ cm Mid-parental Height \_\_\_\_\_ cm

Current Height \_\_\_\_\_ cm \_\_\_\_\_ % ile Bone Age \_\_\_\_\_ yr \_\_\_\_\_ mon

Current Weight \_\_\_\_\_ kg \_\_\_\_\_ % ile Skeletal X-ray Date \_\_\_\_\_

Last Exam \_\_\_\_\_ Predicted Adult Height \_\_\_\_\_ cm

Height Velocity \_\_\_\_\_ cm/yr \_\_\_\_\_ % ile Epiphyses Open?  Yes  No

Mother's Height \_\_\_\_\_ cm IGF-1 Results \_\_\_\_\_

Father's Height \_\_\_\_\_ cm \_\_\_\_\_

## Training By

MD Office or  Pharmacy or  EMD Serono / CFG

## Training Location

MD Office or  Home

## Interim Drug Requested

Yes  No

## Prescription

Physician Name \_\_\_\_\_ Office/Clinic/Institution \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

DEA # \_\_\_\_\_ UPIN # \_\_\_\_\_ NPI # \_\_\_\_\_ Lic # \_\_\_\_\_ Tax ID # \_\_\_\_\_

## Choose a Delivery Device and Drug

**easypod**

Saizen 8.8 mg (5.83 mg/mL concentration) click.easy® and Serofine needles NDC 44087-1080-1

Dose Adjustment Options (check one box)

Off  Greater than 50% Automatic:  10%  25%  50%



**cool.click needle-free delivery** (choose vial size)

Saizen 8.8 mg vial (approx 26.4 IU) NDC 44087-1088-1

Saizen 5 mg vial (approx 15 IU) NDC 44087-1005-2

Volume per Dose \_\_\_\_\_ mL Reconstitution Diluent Vol \_\_\_\_\_ mL/day



**one.click auto-injector pen**

Saizen 8.8 mg (5.83 mg/mL concentration) click.easy and one.click needles NDC 44087-1080-1

Number of clicks \_\_\_\_\_ (0.12 mg per click)



**Needle and syringe** (choose vial size)

Saizen 8.8 mg vial (approx 26.4 IU) NDC 44087-1088-1

Saizen 5 mg vial (approx 15 IU) NDC 44087-1005-2

Volume per Dose \_\_\_\_\_ mL Reconstitution Diluent Vol \_\_\_\_\_ mL/day

## Complete the Following

Preferred Pharmacy (optional) \_\_\_\_\_ Number of Doses per week \_\_\_\_\_ Dose per Injection \_\_\_\_\_ mg/day

Dispense \_\_\_\_\_ months (drug and needles) Number of Refills \_\_\_\_\_ (drug and needles) Total Weekly Dose \_\_\_\_\_ mg/kg/wk

## Physician Certification

I certify that the prescribed therapy is medically necessary, that the information in this SMN is accurate to the best of my knowledge, and that I am aware of the risks and benefits associated with the use of Saizen. I authorize EMD Serono to be my designated agent: (1) to provide any information on this SMN to the insurer of the named patient; and, (2) to forward the above prescription, by fax or other mode of delivery, to the pharmacy chosen by the named patient.

X \_\_\_\_\_ Date \_\_\_\_\_  
(Physician Signature)