Humatrope
somatropin (rDNA origin) for injection
6 mg, 12 mg, 24 mg cartridges, 5 mg vial
DirectConnect

Statement of Medical Necessity for Humatrope® (somatropin [rDNA origin] for injection)

Humatrope® DirectConnect Fax: 1-800-642-5442, Phone: 1-84HUMATROPE (1-844-862-8767)

Please check the boxes below to register your patient and/or request one or more services.

☐ BENEFITS INVESTIGATION ☐ INJECTION TRAINING ☐ REGISTRATION ONLY (no insurance support or injection training needed)

☐ ATTACHED INSTITUTIONAL SMN Check here to submit your own Institutional SMN instead of completing the entire form below. If doing so, ***please fill out only*** Patient Name and Date of Birth in Patient Information, and the entire Prescriber Certification section below.

PATIENT INFORMATION

☐ Translation Services Needed Language: _____ ☐ Temporary Medication Request

Patient is: *(choose one)* ☐ New to Humatrope Therapy ☐ Currently Receiving Humatrope Therapy ☐ Currently Receiving Other Brand of GH Therapy

Patient Name (First, M.I., & Last) _____

Date of Birth ___/___/___

Gender ☐ Male ☐ Female

Patient Address _____

City, State, ZIP _____

Primary Contact _____

Relationship to Patient _____

Home Phone # ___ ___ ☐ Preferred

Work Phone # ___ ___ ☐ Preferred

Other Phone # ___ ___ ☐ Preferred

INSURANCE INFORMATION

Please attach a complete copy of the patient's insurance card, both front and back sides.

☐ No Insurance ☐ Prior Authorization Already Submitted

DIAGNOSIS *(MORE THAN ONE DIAGNOSIS MAY BE SELECTED IF APPROPRIATE.)*

☐ Growth Hormone Deficiency (E23.0)
- ☐ Hypopituitarism (E23.1/E23.0)
- ☐ Panhypopituitarism (E23.0)

☐ Short Stature/Growth Failure/ Growth Retardation (R62.52)
- ☐ SHOX Deficiency (E34.3)

☐ Small for Gestational Age (P05.10), plus
- ☐ Short Stature/Growth Failure (R62.52)
- ☐ Russell-Silver Syndrome (Q87.1)

☐ Turner Syndrome (Q96.9)

MEDICAL ASSESSMENT *(PLEASE ATTACH SUPPORTING DOCUMENTATION. COMPLETING THE SECTION BELOW IS OPTIONAL.)*

NEEDED FOR BOTH PEDIATRIC AND ADULT PATIENTS

☐ IGF-1 Results _____ Dates _____

☐ Thyroid Function Test Results _____ Dates _____

☐ GH Stimulation Test Results _____ Dates _____

Agent _____ Peak GH _____ Dates _____

Agent _____ Peak GH _____ Dates _____

☐ Start Date of GH Treatment (For Current Patients Only) _____

REQUIRED FOR PEDIATRIC PATIENTS ONLY

☐ Pre-treatment Height Velocity _____ cm/year Date _____

☐ Bone Age _____ years _____ months Date _____

☐ Open Epiphyses ☐ Closed Epiphyses

☐ Predicted Adult Height _____ cm Date _____

☐ Growth Chart Attached Date _____

PRESCRIPTION OPTIONS

☐ 6 mg cartridge / HumatroPen® 6 mg
Cartridge NDC: 0002-8147-01 / Pen NDC: 0002-9560-01
Dose range: 0.025-1.50 mg / 0.025 mg increments

☐ 12 mg cartridge / HumatroPen® 12 mg
Cartridge NDC: 0002-8148-01 / Pen NDC: 0002-9561-01
Dose range: 0.05-3.00 mg / 0.05 mg increments

☐ 24 mg cartridge / HumatroPen® 24 mg
Cartridge NDC: 0002-8149-01 / Pen NDC: 0002-9562-01
Dose range: 0.10-6.00 mg / 0.10 mg increments

☐ 5 mg Vial Kit
NDC 0002-7335-11
5 mg vial; diluent amount (1.5-5 mL) _____
Needle gauge/length _____

Dose _____ mg sc/day Dose Frequency _____ times/week Days Supply _____

Number of Refills _____ Needle gauge/length: ☐ 4mm x 32G ☐ 5mm x 31G ☐ 8mm x 31G ☐ Other: _____

Suggested Pharmacy (optional)*: OCEAN BREEZE Phone # _____

*pleted only by a member of the office staff.

Please order syringes and needle gauges for reconstitution and dosing.

PRESCRIBER CERTIFICATIONS

By signing below, I certify that the therapy is medically necessary and that this information is accurate to the best of my knowledge. I also represent that I am disclosing this information for purposes of treatment, payment and/or healthcare operations and otherwise have consent to disclose this information, as well as other medical information that may be disclosed, including medical records of the patient, to Eli Lilly and Company and Lilly USA, LLC and its agents for the purpose of assessing whether the patient qualifies for any reimbursement benefits through the duration of the patient's therapy. I also certify that the patient is aware and has consented to my disclosure of their information to Lilly so that Lilly may contact the patient to further enable these services.

Prescriber Name _____ NPI # _____

DEA License # _____ Tax ID # _____

Phone # ___ ___ Fax # ___ ___

Name of Contact Person _____ Contact Phone # ___ ___

Prescriber Signature _____

Date _____

Dispense as written. No stamps allowed.

Please see Indications for Use and Important Safety Information on the back of this form and accompanying Full Prescribing Information and Patient Information.

See Full Pen User Manual that accompanies the HumatroPen 6 mg, 12 mg, 24 mg.