OmniSource
Phone: 877-456-6794

Statement of Medical Necessity

Please fill out form completely and **fax to 877-828-1052**

Omnitrope
(somatropin [rDNA origin] for injection)

❑ Register patient with OmniSource only ❑ New patient ❑ Restart treatment ❑ Continue treatment

Patient

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 _____ Patient/Caregiver Primary Language _____ Gender ❑ M ❑ F

Insurance

Primary Insurance _____ Insurance Company Phone _____
Subscriber _____ DOB _____ Subscriber ID Number _____
Policy/Employer/Group Number _____
Subscriber _____ DOB _____ Subscriber ID Number _____
Policy/Employer/Group Number _____ **Attach a copy of both sides of the patient's insurance card.**

Diagnosis

Recommended ICD-9

❑ Short Stature/Growth Failure (783.43)
❑ Small for Gestational Age (764.00) or (764.90)
❑ Prader-Willi Syndrome (759.81)
❑ Isolated Growth Hormone Deficiency (253.3)
❑ Iatrogenic Hypopituitarism (253.7)
❑ Panhypopituitarism (253.2)
❑ Other (specify by ICD-9 Code) _____

Medical Assessment

FAX or MAIL Growth Chart With SMN (Required) Fax: 877-828-1052 Mail: OmniSource, 7420 Goodlett Farms, #110, Memphis, TN 38016

Current Height _____ cm _____ % Current Weight _____ kg Growth Velocity _____ cm/y
Bone Age _____ Y _____ M Bone X-Ray Date _____ Chronological Age _____ Y _____ M
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 _____ ng/mL Test _____ Result _____
Agent 2 _____ Peak _____ ng/mL Test _____ Result _____

Documentation Attached (For Both Pediatric and Adult Patients)

❑ Current History/Physical and Clinical Notes
❑ IGF-I _____
❑ Thyroid Function Test Results _____
❑ MRI Results _____

Prescription

❑ **Omnitrope® 5 mg/1.5 mL Cartridge** (NDC 0781-3001-07)
❑ **Omnitrope® Pen 5 Delivery System**
❑ **Omnitrope® 10 mg/1.5 mL Cartridge** (NDC 0781-3004-07)
❑ **Omnitrope® Pen 10 Delivery System**
❑ **Omnitrope® 5.8 mg Vial** (NDC 0781-4004-36)

❑ **Injection Training by an OmniSource Nurse**
❑ **Ship Starter Kit** (kit will include pen delivery system)
❑ **Ship Pen Device Only** ___Pen 5 ___Pen 10

Needle Size
❑ BD Pen Needle 29-gauge (12.7 mm)
❑ BD Pen Needle 31-gauge (5 mm)
❑ BD Pen Needle 31-gauge (8 mm)

❑ **Ancillary Supplies as Needed per Injection** (ie, needles, syringes, alcohol wipes)

❑ SOS (Sandoz OmniStart)

If insurance approval takes more than 10 business days, qualified patients can receive an initial supply of 30 days and if necessary receive up to a total of 90 days of Omnitrope at no cost.

Dose

Dose _____ mg/day _____ days/week Days Supply _____ Refills _____ (months)

Special Instructions

Preferred Pharmacy OCEAN BREEZE _____
Other _____

Physician Certification

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By my signature I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required for Sandoz and its employees or agents to assist in obtaining coverage for Omnitrope human growth hormone and to assist in initiating or continuing Omnitrope therapy. I appoint OmniSource, on my behalf, to convey this prescription to the dispensing pharmacy. I further certify that (a) any service provided through OmniSource 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 OmniSource from any government program or third-party insurer.

Signature* _____ Date _____
Print Name _____ DEA Number _____
Address _____ City _____ State _____ ZIP _____
Office Contact _____ Phone _____ Fax _____
Physician Provider/Tax ID Number _____

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. Example: 3 (three) doses.

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

_____ Dispense as Written
_____ Substitution Allowed

If NP or PA, under direction of Dr. _____

DID YOU RECEIVE THIS FAX BY MISTAKE? If so, we would appreciate you letting us know by calling our Privacy Office at 901-385-3661. Please fax all pages you received to our Privacy Office at 901-261-6717, and then destroy the information as well. If you ARE the intended recipient of this fax, this paragraph does not apply to you.

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