Statement of Medical Necessity

❑ Register Patient with CFG Only

saizen® (somatropin) for injection

Fax toll-free to 877-408-4288
Please call 800-582-7989 with any questions

Attach
❑ Patient Insurance
❑ Patient Authorization
❑ Test Results

Patient (first and last name) ______ Date of Birth ______ Patient's Weight and Height ______

Parent/Legal Guardian (first and last name) ______

❑ Male ❑ Female

Street Address ______ City ______ State ______ Zip ______

Home # (required) ______ Work # ______ Cell # ______

From time to time, EMD Serono develops educational and marketing materials for Saizen® patients. Do we have your permission to send these materials to you? If yes, can we have your email address?

E-mail ______

PATIENT CONSENT AND AUTHORIZATION

In order to participate in EMD Serono's CFG 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 for choosing which prescription products are right for me based on my particular diagnosis.

X (Patient or Legal Guardian Signature) ______ SS Number (Patient or Legal Guardian) ______ Date ______

INSURANCE INFORMATION (Attach copy, front and back, of patient insurance card.)

MEDICAL INFORMATION (Attach medical documentation / test results.)

DIAGNOSIS

	ICD-10-CM		ICD-10-CM
❑ Isolated Growth Hormone Deficiency	E23.0	❑ Drug-induced Hypopituitarism	E23.1
❑ Panhypopituitarism	E23.0	❑ Other ______	______

Has patient previously received growth-hormone therapy? ❑ Yes ❑ No If "Yes," Name of Therapy ______

TRAINING BY

❑ MD Office or ❑ Pharmacy or ❑ EMD Serono / CFG

TRAINING LOCATION

❑ MD Office or ❑ Home or ❑ Web-based or Home Training

INTERIM DRUG REQUESTED ❑ Yes ❑ No

TRANSLATION SERVICES NEEDED ❑ Yes. Language spoken ______

CHOOSE A DELIVERY DEVICE AND DRUG

❑ **easypod®**
- ❑ Saizen® 8.8 mg (5.83 mg/mL concentration)
  - ❑ saizenprep® and Serofine needles — NDC 44087-0016-1
  - ❑ click.easy® and Serofine needles — NDC 44087-1080-1

Dose Adjustment Options (check one box)
❑ Off ❑ Greater than 50% Automatic: ❑ 10% ❑ 25% ❑ 50%

❑ **one.click® auto-injector pen**

- ❑ Saizen® 8.8 mg (5.83 mg/mL concentration)
  - ❑ saizenprep® and one.click® needles — NDC 44087-0016-1
  - ❑ click.easy® and one.click® needles — NDC 44087-1080-1

Number of clicks ______

❑ **cool.click® 2 needle-free delivery** (choose vial size)

- ❑ Saizen® 8.8 mg vial — NDC 44087-1088-1
- ❑ Saizen® 5 mg vial — NDC 44087-1005-2

Volume per Dose ______mL/day Reconstitution Diluent Vol ______mL

❑ **Needle and syringe** (choose vial size)
- ❑ Saizen® 8.8 mg vial — NDC 44087-1088-1
- ❑ Saizen® 5 mg vial — NDC 44087-1005-2

Volume per Dose ______mL/day Reconstitution Diluent Vol ______mL

COMPLETE THE FOLLOWING – Prescription directions/dosing information

Preferred Pharmacy (optional) OCEAN BREEZE ______ Number of Doses per week ______ Dose per Injection ______ mg/day

Dispense ______ months (drug) Total Weekly Dose ______ mg/kg/wk

Refills: Drug ______ refills Device 3 Needles, syringes, pistons, nozzles and vial connectors 12

PHYSICIAN CERTIFICATION

Physician Name ______

Street Address ______ City ______ State ______ Zip ______

Phone ______ Fax ______ Lic # ______

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 (Physician Signature) ______ Date ______

COMMENTS

©2017 EMD Serono, Inc. US-SAI-0613-0003(2)a(3)