



STATEMENT OF MEDICAL NECESSITY

ADULT GROWTH HORMONE TREATMENT



(somatropin) Injection, for subcutaneous use

*= Required field **SMN Fax: 800-545-0612** Phone: 866-688-7674

PATIENT/INSURANCE INFORMATION

*Patient name _____
 *Date of birth _____ *Gender: Male Female
 *Street address _____
 *City _____ *State _____ *Zip _____
 *Primary phone _____ Alternate phone _____
 Alternate contact name _____
 Relationship to patient _____

*Is the patient insured? Yes No
 If yes, please attach front and back of insurance card, and pharmacy card if available.

*Prescription Type:
 New to growth hormone
 Switch from alternative growth hormone
 Continue Nutropin AQ®
 _____ Conversion
(Insurance name)

DIAGNOSIS

*Diagnosis:
 Hypopituitarism (Isolated GHD) (E23.0) Postprocedural hypopituitarism (E89.3) Other diagnosis/ICD-10 Code: _____
 Panhypopituitarism (E23.0) Hypothalamic dysfunction, not elsewhere classified (E23.3) _____
 Drug-induced hypopituitarism (E23.1) Disorder of pituitary gland, unspecified (E23.7) _____

PRESCRIPTION

*Device/Product:
 NuSpin® 20 (0.2 mg dosing increments)
 NuSpin® 10 (0.1 mg dosing increments)
 NuSpin® 5 (0.05 mg dosing increments)

Needles:
 BD Ultra-Fine™ III Short Pen Needle 31 g/8 mm (default if no needle is selected)
 BD Ultra-Fine™ 29 g/12.7 mm
 NovoFine® Pen Needle 30 g/8 mm
 NovoFine® Autocover® 30 g/8 mm
 Other: _____

Dose: _____ mg/inj
 SubQ: _____ inj/week
 Dispense: _____ month supply
 Refill: x _____

SERVICES REQUESTED

PRIORITY REVIEW
 Complete the fields with ***bold text only (see reverse/next page for requirements)**
 NuAccessSM free goods program (see next page for requirements)
 Other: _____

All services below (or check services individually):
 Benefits investigation/prior authorization
 Appeals support
 Co-pay support
 Education kit
 Genentech® Access to Care Foundation patient assistance program
 Injection training/teach

Injection Training/Pharmacy
 Injection training to be arranged by
 Office Nutropin GPS™ Case Manager

Preferred specialty pharmacy: _____

MEDICAL ASSESSMENT

Attach applicable medical records:
 History and physical
 DEXA scan
 Total cholesterol: _____
 HDL: _____ LDL: _____
 Baseline IGF-1 level: _____

Date patient last seen: _____
 Weight: _____
 Height: _____

GH stim test _____ GH stim test _____
 Date: _____/_____/_____
 Agent: _____
 Peak value: _____

Other lab results to support diagnosis (see reverse/next page for diagnosis-specific suggestions)

PRESCRIBER

*Prescriber's last name _____ National Provider Identifier (NPI) _____
 *Prescriber's first name _____ *Specialty _____
 *Address _____ State License Number (SLN) _____
 _____ Phone _____
 *Fax _____ Name of office contact _____
 Practice name _____ E-mail _____

PHYSICIAN CERTIFICATION: By signing below, I certify that I am prescribing Nutropin therapy for the patient named above and that (a) the above therapy is medically necessary and that I will supervise the patient's treatment accordingly, (b) I am not prescribing Nutropin for any of the following purposes: (1) athletic performance, (2) athletic body building, (3) anti-aging or (4) cosmetic use; (c) I have received the necessary authorizations, including those required by state law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to release the above-referenced information and other health and medical information of the patient to Genentech, Inc., its agents and the contracted dispensing pharmacy, for the purpose of requesting reimbursement support, assisting in initiating or continuing therapy and/or the evaluation of the patient's eligibility for GATCF, as a break in treatment would negatively impact the patient's therapeutic outcome; (d) I will not attempt to seek reimbursement for free product provided to the patient; and (e) I request Genentech, Inc., and its agents to convey to the pharmacy chosen by the above-named patient the prescription prescribed herein. I agree to comply with the program guidelines as established by Genentech, Inc., and understand that the Genentech Access to Care Foundation, at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of the information submitted. If applying for GATCF, I certify that (a) this patient has no medical insurance coverage or otherwise meets the financial criteria for the prescribed therapy, and is not eligible for other product financial support programs, and (b) the therapy identified above will not be used in a clinical trial. Note: Prescribers in all states must follow applicable law for a valid prescription and who is considered an authorized prescriber. For prescribers in states with official prescription form requirements, such as New York, please submit prescriptions on an official state prescription blank along with this form. Unapproved Use Warning: Please read the FDA-approved label for Genentech products before prescribing. If the indication for which you are prescribing is not listed in the FDA-approved label, you are prescribing the medication for an "unapproved" use, meaning that the FDA has not approved the efficacy, dosage amount or safety of this medication when used for such a use.

By signing below I request Lash to forward this Statement of Medical Necessity to a dispensing pharmacy on the behalf of my patient while ensuring that in doing so it remains unaltered.

*Prescriber's signature: _____ *Date: _____/_____/_____

(Original or stamped signature required)




INSTRUCTIONS: How to complete the Statement of Medical Necessity for Nutropin AQ® (somatropin) injection, for subcutaneous use for the adult patient

PATIENT/INSURANCE INFORMATION

If attaching insurance information, please include cardholder name, employer, policy #, group #, and BIN # for the insurance and/or pharmacy benefit company. **If available, please attach the front and back of insurance cards and pharmacy cards.**

PRESCRIPTION

The following devices/products are available for Nutropin AQ.

Device/Product	Dosing Increments	NDC
NuSpin® 20 	0.2 mg	50242-076-01
NuSpin® 10 	0.1 mg	50242-074-01
NuSpin® 5 	0.05 mg	50242-075-01

PRIORITY REVIEW

- Use Priority Review to determine if Nutropin AQ is available on formulary.
- For Priority Review, please complete the ***bolded** fields: patient name, date of birth, gender, street, city, state, ZIP, phone, prescription type, diagnosis, device, prescriber name, address, fax, specialty, prescriber signature, date. Check the "Priority Review" box and attach any insurance information.
- For a full benefits investigation, please complete all fields and indicate any services requested.

NuAccessSM

NuAccessSM is a program providing medicine for patients for a limited time while their insurance coverage is being evaluated.

MEDICAL ASSESSMENT

- Please attach the requirements as suggested below.
- When possible, please provide lab results, height, weight, etc. by filling in the appropriate field/check box on the front of the SMN. If documentation is required, please only send what is requested or necessary per the criteria. Providing additional documents or information with this form may delay processing.

ADULT/CHILDHOOD-ONSET

	Panhypopituitarism E23.0	Hypopituitarism (Isolated GHD) E23.0	Drug-induced hypopituitarism E23.1	Postprocedural hypopituitarism E89.3
History and physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of head trauma or defect (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
History of CNS surgery or radiation (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DEXA scan (if available)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stim test results (peak value indicated)	no stim test required if ≥ 3 hormone deficiencies	2 stim tests	2 stim tests	1 stim test
MRI (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Lipid panel (if available)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
List of hormonal deficiencies and/or replacements	<input type="checkbox"/>	<input type="checkbox"/> If applicable	<input type="checkbox"/> If applicable	<input type="checkbox"/>
IGF-1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have questions about insurance criteria, please ask Nutropin GPS™ to contact a Genentech reimbursement representative to discuss the criteria with your office representative.

Nutropingps.com Phone: 866-NUTROPIN 866-688-7674 SMN Fax: 800-545-0612

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Nutropin GPS is a trademark of Genentech, Inc.
BD Ultra-Fine is a trademark of Becton, Dickinson and Company.
NovoFine is a registered trademark of Novo Nordisk A/S.