

STATEMENT OF MEDICAL NECESSITY

ADULT GROWTH HORMONE TREATMENT

SMN Fax: (800) 545-0612

Phone: (866) 688-7674

Nutropin AQ[®] NuSpin[™] **Nutropin gps[™]**
[somatropin (rDNA origin) injection]

SERVICES REQUESTED*
(check all that apply)

- All Services Benefits Investigation Prior Authorization Appeals Support Co-pay Assistance Education Kit
 Genentech[®] Access to Care Foundation Patient Assistance Other: _____

PATIENT

Last name*: _____ First name*: _____ Gender*: Male Female Birth date*: / /
Street: _____ City: _____ State*: _____ ZIP: _____
Home phone: () _____ Work/cell phone: () _____ Email: _____
Alternate contact last name: _____ First name: _____ Phone: () _____
Relationship to patient: _____

INSURANCE: Is the patient insured? Yes No If yes, please provide insurance information. Is the patient pending Medicaid determination? Yes No

Updated Insurance Information:

Cardholder Name: _____ Employer: _____
Medical Insurance Company: _____ Phone: () _____
Policy #: _____ Group #: _____ Bin #: _____
Pharmacy Benefit Company: _____ Phone: () _____
Policy #: _____ Group #: _____ Bin #: _____

DIAGNOSIS

Prescription Type: New start Continued Tx Restart Tx
 Isolated growth hormone deficiency (253.3) Panhypopituitarism (253.2) Iatrogenic-induced hypopituitarism (253.7)
 Other disorder caused by inadequacy of endogenous growth hormone secretion: _____ Specify by ICD-9: _____

MEDICAL ASSESSMENT

Lab Results (for initial diagnosis only): See attached

GH stimulation test 1 date: / / GH stimulation test 2 date: / / Baseline IGF-1 level: _____ Weight: _____ Height: _____
Agent: _____ Peak value: _____ Agent: _____ Peak value: _____ DEXA scan results: _____ Total cholesterol: _____
Date patient last seen: / / Clinical impression: _____ HDL: _____ LDL: _____
Date therapy initiated: / /

PRESCRIPTION

NuSpin		AQ Pen & Cartridge	
<input type="checkbox"/> NuSpin [™] 20 (0.2-mg dosing) Prefilled 20-mg cartridge		<input type="checkbox"/> Nutropin AQ Pen [®] 20 <input type="checkbox"/> 20-mg cartridge (0.2-mg dosing)	
<input type="checkbox"/> NuSpin [™] 10 (0.1-mg dosing) Prefilled 10-mg cartridge		<input type="checkbox"/> Nutropin AQ Pen [®] 10 <input type="checkbox"/> 10-mg cartridge (0.1-mg dosing)	
<input type="checkbox"/> NuSpin [™] 5 (0.05-mg dosing) Prefilled 5-mg cartridge			
<input type="checkbox"/> BD Ultra-Fine [™] 29 g/12.7 mm <input type="checkbox"/> BD Ultra-Fine [™] III Short Pen Needle 31 g/8 mm		<input type="checkbox"/> NovoFine [®] Pen Needle 30 g/8 mm <input type="checkbox"/> BD AutoShield [™] Pen Needle 29 g/8 mm	

Dose: _____ mg/inj SubQ: _____ inj/week Dispense: _____ months Refill X _____ or _____ PRN

TRAINING/ PHARMACY

Injection training to be arranged by: Office Nutropin GPS[™] Case Manager Preferred agency: _____ Preferred specialty pharmacy: _____

PRESCRIBER

Prescriber's last name*: _____ First name*: _____
Practice name: _____ Specialty: _____
Street*: _____ City*: _____ State*: _____ ZIP*: _____
Phone: () _____ Fax: () _____ Prescriber tax ID: _____ Prescriber NPI*: _____
DEA #: _____ Group NPI: _____ State license #: _____ PTAN#: _____

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 evaluating whether the patient qualifies for reimbursement and assisting the patient in initiating or continuing therapy, including but not limited to adherence, education and training programs and/or the evaluation of the patient's eligibility for the Genentech Access to Care Foundation program related to Genentech products as a break in treatment would negatively impact the patient's therapeutic outcome, (d) I will not sell or bill for any free product received in my office for patients from the Genentech Access to Care Foundation, Starter Programs or NuAccess Program, and (e) I appoint Genentech, Inc., and its agents solely to convey on my behalf 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.

Prescriber's Signature* _____ Date* / /
(Original or stamped signature required.)

* Required field. † National Provider Identifier. ‡ Provider Transaction Access Number.

INSTRUCTIONS: How to Complete the Statement of Medical Necessity (SMN) for Nutropin® [somatropin (rDNA origin) for injection] for the Adult Patient

Please write legibly and complete all required fields (*) to prevent delays. This instruction sheet may be used for guidance and as a checklist to assist in the completion of the SMN. IT DOES NOT NEED TO BE FAXED WITH THE SMN.

SERVICES REQUESTED

Check the appropriate services requested. Services cannot be performed without your specific authorization

INSURANCE INFORMATION

If patient is insured, please provide insurance information. If faxing the SMN, please provide a front and back copy of the insurance card (enlarged and legible)

DIAGNOSIS AND MEDICAL INFORMATION

Check the appropriate diagnosis code. If "other" is checked, ICD-9 code is required

The following is a list of what is usually needed by diagnosis (provide on SMN or report as appropriate):

Additional information may be required from your office.

253.3 Isolated Growth Hormone Deficiency

- Any history of head trauma (if appropriate)
- History and physical
- DEXA scan (helpful)
- Lipid profile (helpful)
- Thyroid report (helpful)
- Stim test lab results

253.2 Panhypopituitarism

- MRI
- List of hormonal deficiencies and/or replacements
- History and physical
- DEXA scan (helpful)
- Lipid panel (helpful)
- Thyroid report (helpful)

253.7 Iatrogenic-Induced Hypopituitarism

- MRI
- List of hormonal deficiencies and/or replacements
- History, physical, and cause
- DEXA scan (helpful)
- Stim test lab results

MEDICAL ASSESSMENT

Please indicate the date you last saw the patient (date of these test results), the date therapy was originally initiated (or will be initiated), and the estimated duration of therapy

PRESCRIPTION

Please ensure that you complete all areas of the prescription portion correctly and completely

TRAINING

Please indicate if the Case Manager or the office will arrange training. If the Case Manager is selected, the Nutropin Injection Trainer will contact the patient directly



PRESCRIBER

This form cannot be processed without an original or stamped signature

ATTACH TO COMPLETED SMN

Any insurance card, demographic sheet, recent visit notes, pertinent reports, and/or supporting medical documentation that you feel would assist in obtaining authorization for treatment

REMINDER: This form cannot be processed without a prescriber's signature and date.

Nutropingps.com

Phone: (866) NUTROPIN/(866) 688-7674 **SMN Fax:** (800) 545-0612

Nutropin and Nutropin AQ are registered trademarks and NuSpin and Nutropin GPS are trademarks of Genentech, Inc.
BD Ultra-Fine™, BD Ultra-Fine™ III, and BD AutoShield™ are trademarks of Becton, Dickinson and Company.
NovoFine® is a registered trademark of Novo Nordisk A/S.

Nutropin AQ NuSpin™
[somatropin (rDNA origin) injection]