

STATEMENT OF MEDICAL NECESSITY

PEDIATRIC 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: _____
 Primary 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

Where appropriate, please fill in the 4th digit of the ICD-9 code. Further information is available on the next page.

- Isolated growth hormone deficiency (253.3)
 Panhypopituitarism (253.2)
 Iatrogenic-induced hypopituitarism (253.7)
 Chronic renal insufficiency (chronic kidney disease [585.____])
 Turner syndrome (758.6)
 Short stature/growth failure (783.43)
 Other disorder due to inadequacy of endogenous growth hormone secretion: _____ Specify by ICD-9-CM: _____

MEDICAL ASSESSMENT

Lab Results (for initial diagnosis only):

See attached

GH stimulation test date: ____ / ____ / ____
 Agent: _____ Peak value: _____
 GH stimulation test date: ____ / ____ / ____
 Agent: _____ Peak value: _____

Thyroid test results: _____ IGF-BP3 test results: _____
 Tanner stage of puberty: _____ IGF-I level: _____
 Karyotype results (Turner syndrome only): _____
 GFR (CRI only): _____
 Clinical impression: _____

	Baseline	Current
Date		
Height (cm)		
Height (%)		
Height SDS		
Weight (kg)		
Weight (%)		
Growth velocity		
Bone age		
Date of x-ray		

Date patient last seen: ____ / ____ / ____
 Date therapy initiated: ____ / ____ / ____
 Estimated duration: _____

Epiphysis open: Yes No Growth chart attached: Yes No

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

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

Preferred specialty pharmacy: _____

NUACCESS

<input type="checkbox"/> 30-day supply of free goods and up to 2 refills for eligible patients	Only for patients who have been prescribed NuSpin [™] as indicated above Product will be delivered to the patient's home by Genentech-designated pharmacy Patients must meet medical criteria for initial and subsequent requests
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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 Pediatric 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.

Isolated Growth Hormone Deficiency 253.3

- Two stim test results
- Growth chart (with at least two plots)
- Bone age
- History and physical (helpful)

Chronic Renal Insufficiency 585. _____ (Chronic Kidney Disease)

- Growth chart (with at least two plots)
- Renal function studies
- History and physical (helpful)
- Is patient on dialysis?
- Bone age

Panhypopituitarism 253.2

- MRI
- Growth chart (with at least two plots)
- Bone age
- History and physical (helpful)

Turner Syndrome 758.6

- Growth chart (with at least two plots)
- Karyotype report
- Bone age

Iatrogenic-Induced Hypopituitarism 253.7

- MRI
- Growth chart (with at least two plots)
- Bone age
- History and physical (helpful)

Short Stature/Growth Failure 783.43

- Growth chart (with at least two plots)
- Predicted height from progress report
- Mid-parental height (may be helpful)
- Bone age

Please specify the 4th digit of the ICD-9 code for the Chronic Kidney Disease indication:

Stage 2: 585.2

Stage 3: 585.3

Stage 4: 585.4

Stage 5: 585.5

End Stage: 585.6

MEDICAL ASSESSMENT

Please indicate the date you last saw the patient (date these results are from), 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

NUACCESS

Free goods program is for patients who have been prescribed NuSpin only

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

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