

Register Patient with CFG Only

Patient (first and last name) _____ Date of Birth _____ Male Female

Parent/Legal Guardian (first and last name) _____

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 Connections for Growth 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 responsible 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-9-CM		ICD-9-CM
<input type="checkbox"/> Isolated Growth Hormone Deficiency	253.3	<input type="checkbox"/> Iatrogenic-induced Hypopituitarism	253.7
<input type="checkbox"/> Panhypopituitarism	253.2	<input type="checkbox"/> 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

INTERIM DRUG REQUESTED Yes No

CHOOSE A DELIVERY DEVICE AND DRUG

easypod®



Saizen® 8.8 mg (5.83 mg/mL concentration) click.easy® and Serofine needles NDC 44087-1080-1
Dose Adjustment Options (check one box)
 Off Greater than 50% Automatic: 10% 25% 50

cool.click™2 needle-free delivery (choose vial size)



Saizen® 8.8 mg vial (approx 26.4 IU) NDC 44087-1088-1
 Saizen® 5 mg vial (approx 15 IU) NDC 44087-1005-2
Volume per Dose _____mL/day Reconstitution Diluent Vol _____mL

one.click® auto-injector pen



Saizen® 8.8 mg (5.83 mg/mL concentration) click.easy® and one.click® needles NDC 44087-1080-1
Number of clicks _____ (0.12 mg per click)

Needle and syringe (choose vial size)

Saizen® 8.8 mg vial (approx 26.4 IU) NDC 44087-1088-1
 Saizen® 5 mg vial (approx 15 IU) NDC 44087-1005-2
Volume per Dose _____mL/day Reconstitution Diluent Vol _____mL

COMPLETE THE FOLLOWING – Prescription directions/dosing information

Preferred Pharmacy (optional) _____ Number of Doses per week _____ Dose per Injection _____ mg/day

Dispense _____ months (drug and needles) Number of Refills _____ (drug and needles) Total Weekly Dose _____ mg/kg/wk

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