saizen®
[somatropin (rDNA origin) for injection]

connections for growth®

Ph: 800-582-7989
Fax: 800-408-4288

Patient Authorization

Patient Name ______________________________
Address ______________________________
Home Phone ______________________________
SS Number ______________________________ DOB ____/____/____

Authorization to use and disclose medical, financial and insurance information.

I confirm that I want to participate in EMD Serono's Connections for Growth® for Saizen® and/or easypod™ or cool.click® or one.click®. By signing below, I hereby:

(1) authorize EMD Serono, Inc., and any third parties working with EMD Serono, including but not limited to McKesson Specialty, which helps administer EMD Serono's program, EMD Serono's delivery device-fulfillment centers who send out the easypod, cool.click and one.click devices and nurses who provide injection training and counseling, (collectively, "EMD Serono") to contact my healthcare provider, pharmacy, insurance company or other third-party payors (collectively, "Third Parties") about my medical, financial, insurance or third-party payor information, and information to verify the accuracy of the information I provide in my application or related to my enrollment or participation in EMD Serono's program (my "Information") for the purposes described below, and:

(2) authorize the Third Parties to use and disclose (i.e., to release) all such Information to EMD Serono for the purposes described below; and,

(3) authorize EMD Serono to use and disclose my Information for those same purposes; and,

(4) authorize EMD Serono to disclose Information back to the Third Parties for those same purposes; and,

(5) authorize EMD Serono and Third Parties to disclose Information about me between and among each other for those same purposes.

Purposes for which your Information may be used and disclosed

By signing below, I authorize the use and disclosure of my Information for the following purposes:

- to enroll me in EMD Serono's program;
- to provide me with free medical and clinical information and patient-educational materials about my condition, treatment options, product and program offerings;
- to assist me in obtaining insurance coverage for my prescription drug, and with required documentation needed by insurance companies (including support for appeals), and provide me with information about alternative-payment options, including any applicable patient-assistance programs;

- to help me locate a pharmacy to fill my prescription, if applicable, and to facilitate dispensing of my prescription;
- to provide me with any necessary delivery device and related supplies;
- to provide me with training by a nurse on how to use any necessary delivery device;
- to provide me with information about compliance with the treatments my healthcare provider has prescribed and to have nurses follow up with me about my treatment compliance;
- to monitor the status of my insurance reimbursement, prescription dispensing, device delivery and training, and treatment compliance, and advise my healthcare provider, pharmacy, insurance company or other third-party payors of such status;
- to conduct surveys to measure my patient satisfaction with the program and dispensing and delivery of my prescription and delivery device; and,
- for such other purposes as may be required or permitted by applicable law.

Authorization to forward prescription to pharmacy

By signing below, I authorize EMD Serono and the Third Parties to send, via fax or other mode of delivery, my prescription to the pharmacy of my choosing.

Terms of this Authorization

This authorization has no expiration date. It is a permanent authorization (unless and until it is revoked). I understand that: (1) I can revoke this authorization by notifying EMD Serono in writing and the revocation is not effective as to actions any party took in reliance on the authorization; (2) once my Information is disclosed to Third Parties under this authorization, some of it may not be protected; (3) I can refuse to sign this form (but then I can't participate in the program); (4) EMD Serono reserves the right to, at any time and without notice: (a) modify the application form and the eligibility criteria; (b) modify or discontinue any or all aspects of the program; and (c) terminate any assistance provided by the program; (5) I have the right to receive a copy of this form; and, (6) my prescribing physician is responsible for choosing which prescription products are right for me based upon my particular diagnosis.

Check this box for more information:

❏ I authorize EMD Serono and the Third Parties to send me up-to-date medical and promotional information on my prescription drug and additional EMD Serono programs, services and products which may be of interest to me.

Signature of patient or parent/legal guardian ______________________________

Date ____________________

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