



# Statement of Medical Necessity



Fax toll-free to  
**877-408-4288**  
Please call  
**800-582-7989**  
with any questions

**Attach**  
 Patient Insurance  
 Patient Authorization  
 Test Results

Register Patient  
with CFG Only

Patient (first and last name) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Patient's Weight \_\_\_\_\_

Parent/Legal Guardian (first and last name) \_\_\_\_\_  Male  Female

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

#### 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)

#### 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

#### 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