

OmniSource is a comprehensive support center dedicated to helping children with growth hormone deficiency, as well as their families and healthcare team. The people at OmniSource are committed to answering your questions, helping to facilitate the insurance process, providing a Starter Kit when insurance coverage is approved, and providing training with an OmniSource nurse for the first injection if your child's doctor requests it. See the back of this form for more highlights of the OmniSource Patient Support Program.

To ensure your registration with OmniSource, please read this entire form and sign in the spaces indicated. You and/or your healthcare team should fax this signed form to OmniSource at the number above.

Patient/Parent/Legal Guardian Name (print) _____ Relationship to Patient _____

Address _____ City _____ State _____ ZIP _____

Home Phone _____ Work or Cell Phone _____

Release for Prescription and Payment

I authorize my Doctor and his/her staff, my employer, my health insurer and/or specialty pharmacy to disclose my protected health information (PHI) (as noted on the Statement of Medical Necessity) to Sandoz, its affiliates and its agents who have been hired to administer the OmniSource Patient Support Program to use and/or disclose, as needed, to coordinate the receipt, payment, and proper administration of Omnitrope as prescribed by my Doctor. I understand that once my health information is disclosed it may no longer be protected by federal law regarding patient privacy and that neither my Doctor, my employer, nor my health insurer can guarantee that it will not be re-disclosed to a third party. I understand that I may refuse to sign this Authorization and my refusal or future revocation will not affect the commencement, continuation, or quality of my treatment by my Doctor; however, I may no longer be eligible for the OmniSource Patient Support Program. This Authorization is valid for 5 years after the date of my signature. I acknowledge that I would like to participate in the OmniSource Patient Support Program. I understand that by enrolling in the program, the program will contact me directly to follow up on my therapy.

Patient/Parent/Legal Guardian Signature _____ Date _____

I authorize Sandoz to use and disclose personal information, including health information, it receives about me to a specialty pharmacy that will fill my prescription and may invite me to participate in disease management programs. I understand and agree that my personal information may be used and disclosed by the specialty pharmacy and shared with Sandoz for reimbursement purposes and for the administration of the OmniSource Patient Support Program. I understand that Sandoz will not release my information to any other party without my express consent. I understand that I may refuse to sign or may revoke (at any time) this Authorization. I understand that if I revoke this Authorization, I will no longer be able to participate in the OmniSource Patient Support Program. To revoke this Authorization contact 877-456-6794. This Authorization is valid for 5 years after the date of my signature. I also understand that the OmniSource Patient Support Program may be changed or ended at any time without prior notification. I understand that I may receive a copy of this Authorization.

Patient/Parent/Legal Guardian Signature _____ Date _____

Patient Support Program Consent

Yes! In addition to the prescription and reimbursement components of the OmniSource Patient Support Program, I would also like to sign up to receive additional product information and services from Sandoz.

By signing below, I agree that Sandoz and its agents may use and disclose my personal information to deliver these services and may share information with my healthcare professional for the purposes of monitoring and managing my health. Sandoz may also contact me to solicit my opinions regarding their products and services. I may cancel this program at any time by calling 877-456-6794.

Yes, I agree to receive calls from the OmniSource Patient Support Program and Sandoz notifying me of important changes and updates and to solicit my feedback on programs and services at the phone number indicated below. I understand that my cell phone carrier's standard rates may apply for calls or text messages to my cell phone.

Patient Telephone Number _____

Use Telephone Number on the Statement of Medical Necessity

Patient/Parent/Legal Guardian Signature _____ Date _____



Introducing **OmniSource**

Rooted in customer commitment

Complete the form on the reverse side to
access comprehensive insurance services
and product support for **Omnitrope[®]**

- Expert assistance with insurance approvals
- Answers to your questions about insurance coverage and treatment with Omnitrope
- Training for the first Omnitrope injection with an OmniSource nurse at the request of your child's doctor
- An Omnitrope Starter Kit when insurance coverage is approved
- Friendly, personalized service from a caring, knowledgeable OmniSource Specialist

***To register, simply complete the reverse side of this form.
You and/or your healthcare team can fax this form to
OmniSource at 877-828-1052.***