

Register patient with OmniSource only New patient Restart treatment Continue treatment

Patient

Patient Name Date of Birth (DOB) Parent/Guardian Name Relationship to Patient Address City State ZIP Home Phone Work or Cell Phone Social Security Number Allergies Patient/Caregiver Primary Language Gender M F

Insurance

Primary Insurance Insurance Company Phone Subscriber DOB Subscriber ID Number Policy/Employer/Group Number Subscriber DOB Subscriber ID Number Policy/Employer/Group Number Attach a copy of both sides of the patient's insurance card.

Diagnosis

Pediatric Diagnosis Adult Diagnosis Type of Growth Hormone Deficiency Other Isolated Growth Hormone Deficiency (253.3) Isolated Growth Hormone Deficiency (253.3) Childhood-Onset Iatrogenic Hypopituitarism (253.7) Iatrogenic Hypopituitarism (253.7) Adult-Onset Panhypopituitarism (253.2) Panhypopituitarism (253.2)

Medical Assessment

FAX or MAIL Growth Chart With SMN (Required) Fax: 877-828-1052 Mail: OmniSource, 7420 Goodlett Farms, #110, Memphis, TN 38016 Current Height cm % Current Weight kg Growth Velocity cm/y Bone Age Y M Bone X-Ray Date Chronological Age Y M Birth Mother's Height cm Birth Father's Height cm Predicted Adult Height cm Growth Hormone Stimulation Test Date Other Lab Tests Agent 1 Peak ng/mL Test Result Agent 2 Peak ng/mL Test Result Documentation Attached (For Both Pediatric and Adult Patients) Current History/Physical and Clinical Notes Thyroid Function Test Results IGF-I MRI Results

Prescription

Omnitrope 5 mg/1.5 mL Cartridge (NDC 0781-3001-07) Omnitrope Pen 5 Delivery System Omnitrope 10 mg/1.5 mL Cartridge (NDC 0781-3004-07) Omnitrope Pen 10 Delivery System Omnitrope 5.8 mg Vial (NDC 0781-4004-36) Injection Training by an OmniSource Nurse Ship Starter Kit (kit will include pen delivery system) Ship Pen Device Only Pen 5 Pen 10 Needle Size BD Pen Needle 29-gauge (12.7 mm) BD Pen Needle 31-gauge (5 mm) BD Pen Needle 31-gauge (8 mm) Ancillary Supplies as Needed per Injection (ie, needles, syringes, alcohol wipes) SOS (Sandoz OmniStart) Send an SOS by checking this box. Qualified patients can receive an initial 30-day supply of Omnitrope at no cost if the insurance approval process extends beyond 10 business days.

Dose

Dose mg/day days/week Days Supply Refills (months)

Special Instructions

Preferred Pharmacy Other

Physician Certification

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By my signature I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required for Sandoz and its employees or agents to assist in obtaining coverage for Omnitrope human growth hormone and to assist in initiating or continuing Omnitrope therapy. I appoint OmniSource, on my behalf, to convey this prescription to the dispensing pharmacy. I further certify that (a) any service provided through OmniSource on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use Omnitrope or any other Sandoz product or service for anyone, and (b) my decision to prescribe Omnitrope was based solely on my determination of medical necessity as set forth herein, and that (c) I will not seek reimbursement for any medication or service provided by or through OmniSource from any government program or third-party insurer. Signature\* Date Print Name DEA Number Address City State ZIP Office Contact Phone Fax Physician Provider/Tax ID Number Prescriber's full signature. Actual signature is required--no stamps. Prescriber certifies this is his/her full and usual signature. Note: TN prescribers--quantity must be written in both numerals and words. Example: 3 (three) doses. Dispense as Written Substitution Allowed IF NP or PA, under direction of Dr. DID YOU RECEIVE THIS FAX BY MISTAKE? If so, we would appreciate you letting us know by calling our Privacy Office at (901) 385-3661. Please fax all pages you received to our Privacy Office at (901) 261-6717, and then destroy the information as well. If you ARE the intended recipient of this fax, this paragraph does not apply to you. Confidentiality Notice: This facsimile is intended for the sole use of the individual and entity to which it is addressed, and may contain information that is proprietary, confidential, privileged, and prohibited from being disclosed under applicable law. If you are not the intended addressee, nor authorized to receive for the intended addressee, you are hereby notified that you may not use, copy, disclose, or distribute to anyone the facsimile or any information contained in the facsimile. Proherant Health, Inc. is a division of Accredo Health Group, Inc., a wholly owned subsidiary of Medco Health Solutions, Inc. Accredo CBS is a registered trademark of Accredo Health Group, Inc., GH-100606-2.

# Omnitrope® SMN Reminder

- Attach a copy of both sides of the patient's insurance card
- Indicate the patient's diagnosis
- Include the patient's growth chart and test results as indicated in the Medical Assessment section
- Complete the Prescription section

**Fax the SMN form and the other documents to 877-828-1052.**

## Omnitrope®

(somatotropin [rDNA origin] for injection)

### Omnitrope: The growing choice

- One of only three growth hormone products available in a liquid formulation
- Easy-to-administer, cost-effective formulations—Omnitrope Pen 5, Omnitrope Pen 10, and the Omnitrope 5.8 mg Vial



- Comprehensive services and support with OmniSource, a support center dedicated to children and their families

Please see full Prescribing Information attached on the pocket.