ZOMACTON®
(somatropin) for Injection
5mg and 10mg

ZoGo Support Program Enrollment Form

Please fax to 1-844-402-1027 or e-mail to
zomacton_support@occamhealth.com
Phone: 1-844-944-ZOGO (9646)
www.zomacton.com

STATEMENT OF MEDICAL NECESSITY

Check here to request an investigation of benefits and cash offer ONLY. If checked, page 3 does not need to be completed and patients will only be screened for benefit verification and (if applicable) cash pricing. For additional services such as financial assistance or help with copay programs, patient consent is required by patients completing page 3 below.

Patient Information

Pediatric **Adult**

Patient Name (First and Last)____________________ Date of Birth ____/____/____ Gender M F

Address____________________ City____________ State______ ZIP________

Home Phone (___) ___-____ Work Phone (___) ___-____ Parent/Guardian Name____________________

Cell Phone (___) ___-____ Email____________________ Primary Language____________________

Current Height_______cm_______% Current Weight_______kg_____% Allergies: None Other____________________

Insurance Information or Attach Legible Copy of Insurance Card (Front and Back)

Primary Insurance____________________ Pharmacy Insurance ______________ Cash Pay

Insurance Company Phone (___) ___-____ Pharmacy ID #______________ No insurance

Patient ID # ____________________ RX PCN #________ RX BIN #________ Please submit to patients insurance

Group #____________________ Rx Group ______________ Pharmacy Benefit Manager Phone (___) ___-____

Common ICD-10 Codes

GH deficiency (includes hypopituitarism & panhypopit) (E23.0)*

Postprocedural hypopituitarism (E89.3)*

Hypopituitarism iatrogenic NEC (E23.1)*

Idiopathic Short Stature (ISS) (R62.52)

Small for gestational age (SGA)

Small for dates (P05.__________) plus growth failure)

Turner syndrome (Q96.__________).

Short stature due to endocrine disorder (SHOX) (E34.3)

Other ____________________

Medical Assessment (please include medical notes and any supporting lab work)

Bone Age ______Y ______M Standard Deviation Weight __________

Bone X-Ray Date: ____/____/____ Growth Velocity _______cm/yr ______%

Standard Deviation Height __________cm Predicted Height __________cm

Adult Only

LH ______________

TSH ______________

FSH ______________

ACTH______________

Growth Hormone Stimulation Test Date: ____/____/____

Agent	Peak	
Agent 1:	Peak:	ng/mL
Agent 2:	Peak:	ng/mL

Previous Growth Hormone Therapy: Y N
If yes, start date ____/____/____ and product: __________

Test	Result
IGF-1:	Result:
Other Test:	Result:

Special Instructions (check all applicable boxes)

Virtual Nurse Injection Training

Other____________________

Preferred Pharmacy____________________

Has prior authorization been obtained for any GH Yes No
if yes, Date ____/____/____ + PPA#______________

*Post Procedural Hypopituitarism is only for GHD. ZOMACTON® is a registered trademarks of Ferring B.V. © 2022 Ferring B.V. All rights reserved. US-ZN-2100019

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Prescription Options for ZOMACTON® (choose A or B, plus any additional accessories needed)

A. ZOMACTON 10mg	B. ZOMACTON 5mg		Additional Accessories
B-D 30 UNIT	B-D 30 UNIT	3cc syringe, 23g 5/8" needle	Inject Ease Device
B-D 50 UNIT	B-D 50 UNIT	Other	Sharps Container
B-D 100 UNIT	B-D 100 UNIT	(Mix with ____mL of diluent)	Alcohol Swabs
Other	Other	Doctor must complete for 5mg	

Dose to Be Given

Dose________________mg/day____________days/wk Days Supply: 30 90 Refills________

Physician Certification

I verify that the patient and healthcare provider information on this enrollment form was completed by me or at my direction and I have discussed with my patient and informed patient of enrollment in the Zogo Patient Support Program. The information contained herein is complete and accurate to the best of my knowledge. I understand that I must comply with my practicing state's specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements may result in the dispensing pharmacy reaching out to me. By signing below, I certify that: (1) I am prescribing ZOMACTON® (somatropin) (Product) for the patient identified on page 1, this prescription is medically necessary for the patient and that it will be used as directed; I will be supervising the patient's treatment, and that the information I have provided above is complete and accurate to the best of my knowledge; (2) I have received the appropriate permission and consent from the patient to comply with applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and applicable state laws needed to release to Ferring and its designated agents and service providers the patient-related information on this form for the purposes of verifying the patient's insurance coverage for Product, confirming prior authorization requirements for the Product, if needed, on my patient's behalf, providing information on appeals of denials of claims, assisting with financial assistance resources and information, such as co-pay support programs for which the patient may be eligible, coordinating delivery of Product, contacting the patient with education materials and training services about the patient's prescription medication or to evaluate the effectiveness of the Program; and providing my patient with other education and support available through the Program associated with the Product; and (3) If applicable, I authorize the above prescription to be forwarded to the specialty pharmacy affiliated with patient's insurance plan or chosen by the named patient or by my office on the named patient's behalf. Ferring may change or cancel the Program at any time and Ferring reserves the right to terminate my patient's enrollment any time; (4) I will notify Ferring immediately if the Product is no longer medically necessary for this patient's treatment or if my patient's insurance or financial status changes.

Physician Signature (required) ____ Date_____/_____/_____

Print Name__________________________ National Provider ID (NPI)____________________ DEA #__________

Address______________________________________ City____________________ State_____ ZIP ________

Office Contact________________________ Phone (____) ____-_____ Fax (____) ____-_____ Tax ID: __________

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PATIENT TERMS OF PARTICIPATION, FINANCIAL ELIGIBILITY AND PATIENT PRIVACY NOTICE

I, or my authorized representative, request that information regarding my medical condition, prescription for ZOMACTON® (somatropin) ("Product"), financial information and insurance coverage (the "Authorized Information") to be released and disclosed to Ferring, and any other authorized parties ("Recipients"), as follows: I understand that my Authorized Information will be used to: (1) Enroll me or initiate my enrollment in Zogo Patient Support ("Program"); (2) Establish my benefit eligibility and potential out-of-pocket costs for Product and to provide me with related services, including directing me to separate private or public payer programs, reimbursement services, services to ship my medication, and other support services including patient education materials and training services and financial assistance (if and to the extent applicable); (3) Determine my eligibility for and help me access any applicable co-pay support or (4) Perform research and data analytics to develop and evaluate products, services, materials, and treatments; (5) Communicate with my healthcare providers and health plans about my treatment plan; (6) Contact me for reasons related to the Program and all support services, to obtain further information or clarification regarding any adverse event that I may experience, or to solicit my opinions regarding any drug administered under Program, and Ferring's products and services; (7) Administer and maintain the quality of the Program, including but not limited to case review, compliance checks, audit review and accounting purposes; and (8) Help get Product shipped to me or my healthcare providers.

I understand that once my Authorized Information has been disclosed to Ferring, it may no longer be protected by federal privacy law and could be re-disclosed to others but that Ferring intends to use and disclose my Authorized Information received pursuant to this authorization only for the purposes described above or as required by law.

I understand the Pharmacy that is dispensing my Product may receive financial remuneration from Ferring for disclosing my Authorized Information to Ferring and for providing support services to me, including sending communications to me, for purposes of my participation in the program detailed in this authorization.

I would also like to receive information from Ferring via mail or email, which may include disease state educational material and information about Product and Ferring. I understand that I can withdraw this authorization by calling ZoGo Patient Support at 1-844-944-ZoGo (9646).

I understand that if I do revoke the authorization, it will thereafter be invalid, but that uses and disclosures made in reliance on the authorization prior to its revocation will not be invalidated. I understand that I may refuse to sign this form and, if I do so, I will not be able to participate in Program, but such refusal will not affect my eligibility to obtain medical treatment, or to be prescribed the Product, if applicable, or eligibility for insurance coverage, or other benefits. This authorization expires 3 years after the date I sign it below. I understand that I am entitled to receive a copy of this authorization.

My signature below certifies that I have provided accurate and complete information, that I have read, understood, and agree to the release of my protected health information pursuant to the Patient Privacy Notice. Further information about Ferring's privacy practices can be found here https://ferringusa.com/privacy/

Patient Name (printed): ______________________________

Patient Parent/Guardian Name (printed, if applicable): ______________________________

Relationship to Patient (printed, if applicable): ______________________________

Signature of Patient or Parent/Guardian: ______________________________ Date:____/____/____