

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)*		Idiopathic Short Stature (ISS) (R62.52) Small for gestational age (SGA)
	Postprocedural hypopituitarism (E89.3)*		Turner syndrome (Q96. _____). Short stature due to endocrine disorder (SHOX) (E34.3)
	Hypopituitarism iatrogenic NEC (E23.1)*		Small for dates (P05. _____) plus growth failure Other _____
Medical Assessment (please include medical notes and any supporting lab work)	Bone Age _____ Y _____ M	Standard Deviation Weight _____	Adult Only
	Bone X-Ray Date: ____ / ____ / ____	Growth Velocity _____ cm/yr _____ %	LH _____
	Standard Deviation Height _____ cm	Predicted Height _____ cm	TSH _____
	Growth Hormone Stimulation Test Date: ____ / ____ / ____		FSH _____
	Agent 1: _____	Peak: _____ ng/mL	ACTH _____
	Agent 2: _____	Peak: _____ ng/mL	Previous Growth Hormone Therapy: Y N If yes, start date ____ / ____ / ____ and product: _____
		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 trademark of Ferring B.V. ©2023 Ferring B.V. All rights reserved. US-ZN-2100019 v4

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Prescription Options for ZOMACTON[®] (choose A or B, plus any additional accessories needed)	A. ZOMACTON 10 mg	B. ZOMACTON 5 mg	Additional Accessories
	B-D 30 UNIT	B-D 30 UNIT	Sharps Container
	B-D 50 UNIT	B-D 50 UNIT	Alcohol Swabs
	B-D 100 UNIT	B-D 100 UNIT	
Other	Other	3cc syringe, 23 g 5/8" needle Other _____ (Mix with _____ mL of diluent) Doctor must complete for 5 mg	

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 copay 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: _____



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 copay 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.

Privacy and Marketing Notice

In connection with the Program, Ferring is collecting the following categories of personal information:

- Personal identifiers, including your name, address, email address and phone number; demographic information, including your gender and data of birth
- Characteristics of protected classifications, including your gender
- Audio and visual information, including your voice recordings (when you participate in the Program)
- Sensitive Personal Information, including your state license identification number, health condition information, prescription information, and other categories of health related information

Ferring collects this information for purposes described above in connection with the Program. Ferring may also use your information to send you information from via mail or email, which may include disease state educational material and information about Product and Ferring. You can unsubscribe from this use at anytime. Ferring will keep each category of your personal information listed above for as long as is needed to carry out the purposes described above and in its privacy policy available at <https://ferringusa.com/privacy/>, or as otherwise required by law to satisfy Ferring's legal obligations. Ferring does not knowingly "sell" the information collected from this form, however, Ferring may share your information with trusted third parties in limited circumstances as described and in its privacy policy, which you can access by visiting <https://ferringusa.com/privacy/>. If you decide you would like to exercise any of your privacy rights, including the right to access, delete or correct your information collected via this form, or to limit the sharing of your information with third-parties collected via this form, you may advise us at any time by calling the toll free number 1-888-FERRING (1-888-337-7464) or submitting a Data Subject Contact Form. A link to the Data Subject Contact Form can be found by visiting the Ferring privacy policy at <https://ferringusa.com/privacy/>. Further information about Ferring's privacy practices can be found here <https://ferringusa.com/privacy/>.

My signature below certifies that I have provided accurate and complete information, that I have read, understood, and agree to the release of my Authorized Information pursuant to the Patient Privacy Notice and to the terms of the Privacy and Marketing Notices above.

Patient Name (printed): _____

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

Relationship to Patient (printed, if applicable): _____

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