ZOMACTON™
[somatropin (rDNA origin)] for Injection
5mg and 10mg

ZoGo Support Program Enrollment Form

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

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

PATIENT

Patient Name:	DOB: / /	Gender: ☐ M ☐ F
Patient Address:	City:	ST: ZIP:
Parent/Guardian Name:	Home Phone #:	Work/Cell Phone #:
E-mail Address:	Primary Language:	
OK to contact parent/guardian by phone ☐ or email ☐	Cash Pay ☐	Please submit to patient's insurance ☐

INSURANCE

Please attach front and back of patient's insurance card, prescription benefits card, and/or Medicaid card. Has prior authorization been obtained? ☐ Y ☐ N

Primary Insurance:		Insurance Phone #:
Subscriber Name:		Secondary Insurance:
ID #:	Group #:	Medicaid ID #:

DIAGNOSIS

☐ Isolated Growth Hormone Deficiency (ICD-10 E23.0) ☐ Other:_____

MEDICAL ASSESSMENT

Required: Fax or e-mail all supporting documentation such as bone age reports, stimulation test agents and lab results, growth charts, and progress notes to assist in the prior authorization process.

Current Height _____cm _____%	Current Weight _____kg _____%	Growth Velocity _____cm/yr _____%
Bone Age _____Y _____M	Bone X-Ray Date ____/____/____	Allergies ☐ Y_____ ☐ N
Birth Mother's Height _____cm	Birth Father's Height _____cm	Predicted Height _____cm

Growth Hormone Stimulation Test Date: / /	Other Lab Tests:
Agent 1: Peak: ng/mL	IGF-1: Result:
Agent 2: Peak: ng/mL	Test: Result:

PRESCRIPTION

ZOMACTON™ 5 mg with:
☐ Syringe ☐ ZOMA-Jet™ 5
☐ Syringe and Inject-Ease®

ZOMACTON™ 10 mg with:
☐ Syringe
☐ Syringe and Inject-Ease®

Preferred injection syringe with ultra fine short needle *(B-D required for Inject-Ease®)*:
☐ B-D **30** unit ☐ B-D **50** unit ☐ B-D **100** unit
☐ Other:

Preferred diluent syringe for reconstitution
☐ 3cc syringe with 23g 5/8" needle
☐ Other:

☐ Sharps container
☐ Alcohol swabs
☐ Interim product for qualified patients

Preferred specialty pharmacy: OCEAN BREEZE

DOSAGE

Vial/Syringe and Inject-Ease®

Dose: _____ mg/injection _____ days per week

Dilute: vial with _____mL/diluent* ☐ 30-day ☐ 90-day ☐ Refill: X _____

Sig:_____

*Diluent dispensed with ZOMACTON™ 5 mg has a volume of 5 mL, 10 mg has a volume of 1 mL

ZOMA-Jet™ 5 ☐ Vial Adapter 5 mg Needle-Free Head: A ☐ or B ☐

Dose: _____ mg/injection (must be in increments of 0.05 mg) _____ days per week

Dilute: 5-mg vial with **1 mL/diluent** *ZOMACTON™ sig when using ZOMA-Jet™ 5 (max dose 2.5 mg)*

☐ 30-day ☐ 90-day ☐ Refill: X _____ ☐ Patient needle phobic (F40.231)

INJECTION TRAINING

☐ In-home injection training by ZoGo Support Nurse.

PHYSICIAN

Name:		Office Contact:
Address:		City: ST: ZIP:
NPI #:	DEA #: Tax ID #:	Phone: Fax #:

By my signature, I authorize Occam Health Services, which operates the ZoGo Patient Support Program, and its agents (collectively the "Hub") to use the information provided on this form for the purposes of verifying patient insurance coverage and benefits for ZOMACTON™, referring the patient to the ZOMACTON™ Patient Assistance Program in the event the patient does not have insurance, arranging home-based training, providing educational materials, and performing business operations activities in support of these functions. I certify that I have patient consent to release this information for these purposes and that I have a signed copy on file of this patient's authorization (in a form that complies with all applicable state and federal laws) that allows me and the patient's health insurers to use and disclose the patient's health information, including his or her medical and insurance coverage information and records, to the Hub, the ZOMACTON™ Patient Assistance Program, and their respective agents for the purposes described above. I understand and agree that I remain responsible for complying with all applicable federal and state laws regarding patient privacy. The authorization form signed by the patient that I have on file informs the patient that: (a) the information disclosed may include the patient's health status; (b) the patient's information may be subject to re-disclosure by the recipients and no longer protected by state or federal privacy laws; and (c) I will not condition the patient's treatment, payment, enrollment in a health plan, or eligibility for benefits on the patient providing the requested authorization. I am aware that the patient has the right to revoke the authorization at any time by calling the Hub at 1-844-944-9646 and that such revocation would end the patient's eligibility to participate in the ZoGo Patient Support Program, and that if the patient revokes the authorization, the revocation will prohibit disclosures after the date the written revocation is received, but will not affect previous disclosures made in reliance on the patient's authorization. The patient's signature will be maintained and available for audit purposes as required by all applicable state and federal privacy laws. To the best of my knowledge, all information contained in this form is correct and complete and consistent with applicable privacy laws and regulations, and I understand that the Hub is relying on this representation.

Physician Authorization X_____ Date / /

IF YOU RECEIVED THIS IN ERROR, PLEASE FAX ALL PAGES TO 1-844-402-1027 OR E-MAIL TO ZOMACTON_SUPPORT@OCCAMHEALTH.COM

ZoGo Support Program

Please see Indication for ZOMACTON™ and Important Safety Information on the back.

FERRING PHARMACEUTICALS