E-Z SMN

☐ Pediatric ☐ Adult

Pfizer BRIDGE PROGRAM*

Fax to: 1-800-479-2562
Number of pages in fax: _____
Phone: 1-800-645-1280

Genotropin®
(somatropin [rDNA origin] for injection)

STATEMENT OF MEDICAL NECESSITY (ICD-10)

Patient Information

Patient Name (First and Last) _____ Date of Birth _____
Address _____ City _____ State _____ ZIP _____
Home Phone _____ Work Phone _____ Parent/Guardian Name _____
Cell Phone _____ Gender ☐ M ☐ F Primary Language _____
Current Height _____ cm _____ % Current Weight _____ kg _____ % Allergies: ☐ None ☐ Other _____
List of medications _____

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

Primary Insurance _____ Patient ID # _____ Insurance Company Phone _____
Pharmacy Insurance _____ Pharmacy ID # _____ Pharmacy Benefit Manager Phone _____
☐ No insurance

Diagnosis
See reverse side for Pediatric and Adult diagnosis-specific documentation requirements that may be needed by insurers

☐ Hypopituitarism (includes isolated GHD and panhypopituitarism) (E23.0)
☐ Postprocedural hypopituitarism (E89.3)
☐ Hypopituitarism iatrogenic NEC (E23.1)
☐ Newborn, small for gestational age (P05._____)
See reverse side for weight-based Newborn, small for gestational age codes.
☐ Short stature (child) (R62.52)
☐ Turner syndrome Karyotype 45,X (Q96.0)
☐ Turner syndrome Karyotype 46,X iso (Xq) (Q96.1)
☐ Turner syndrome Karyotype 46,X with abnormal chromosome except iso (Xq) (Q96.2)
☐ Turner syndrome Mosaicism 45, X/46, XX or XY (Q96.3)
☐ Turner syndrome Mosaicism, 45, X/other cell line(s) with abnormal sex chromosome (Q96.4)
☐ Other variants of Turner syndrome (Q96.8)
☐ Turner syndrome, unspecified (Q96.9)
☐ Congenital malformation syndromes predominantly associated with short stature (includes Prader-Willi syndrome) (Q87.1)
☐ Other FDA-Approved Diagnosis (ICD-10) _____

Prescription Options for *GENOTROPIN®*
(choose A, B, C, or D, plus choose pen needle or insulin syringe size)

☐ **A. GENOTROPIN Pen® 5**
Growth Hormone Delivery Device
(dose in increments of 0.1 mg)
☐ 5 mg **GENOTROPIN** (5 mg/mL)
Pen Needle Gauge
☐ 29 ☐ 31

☐ **B. GENOTROPIN Pen® 12**
Growth Hormone Delivery Device
(dose in increments of 0.2 mg)
☐ 12 mg **GENOTROPIN** (12 mg/mL)
Pen Needle Gauge
☐ 29 ☐ 31

☐ **C. GENOTROPIN MiniQuick®**
is available in 10 strengths, each in a package of 7. After reconstitution, each strength delivers a fixed volume of 0.25 mL.
Please select strength
☐ 0.2 mg ☐ 0.4 mg ☐ 0.6 mg
☐ 0.8 mg ☐ 1.0 mg ☐ 1.2 mg
☐ 1.4 mg ☐ 1.6 mg ☐ 1.8 mg
☐ 2.0 mg

☐ **D. GENOTROPIN Mixer®**
Reconstitution Device
Choose Cartridge
☐ 5 mg **GENOTROPIN** (5 mg/mL)
☐ 12 mg **GENOTROPIN** (12 mg/mL)
Insulin Syringe
☐ 0.3 mL ☐ 0.5 mL ☐ 1.0 mL
Needle Gauge
☐ 29 ☐ 31 ☐ Other _____
☐ Dental Needles

Dose to Be Given Subcutaneously

Daily Dose _____ mg/day _____ days/wk Days Supply: ☐ 30 ☐ 90 Refills _____

Special Instructions
(check all applicable boxes)

☐ One-on-One Nurse-to-Patient Training Requested
☐ Case Management Not Requested
☐ GENOTROPIN Copay Program
☐ Requested Interim Care

Preferred Pharmacy – OCEAN BREEZE
Other _____

Physician Certification

1) I certify that the treatment listed above is and will be medically necessary based on my best professional judgment, and that the information provided above is complete and accurate to the best of my knowledge. **2)** I also certify that I have obtained the written permission of the patient (or the patient's legal representative) to disclose the information here and such other health or personal information to the Pfizer Bridge Program® (the "Program"), Pfizer, and/or its agents as may be necessary for the patient's participation in the Program and for the Program. Pfizer and/or its agents may use such information as necessary to provide reimbursement support and other patient management services to the patient in connection with the patient's GENOTROPIN therapy. (A signed copy of a Pfizer Bridge Program Patient Authorization Form [the "Authorization"] either accompanies this completed Statement of Medical Necessity or, to the best of the undersigned's knowledge, is already on file with the Pfizer Bridge Program.) I understand that the Program may use and disclose this information only in accordance with the Authorization. **3)** I further certify that (a) any service provided through the Program 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 GENOTROPIN or any other Pfizer product or service for anyone and (b) my decision to prescribe GENOTROPIN was based on my determination of medical necessity as set forth herein. **4)** I authorize and appoint the Program to convey prescriptions delivered to the Program for GENOTROPIN to the applicable dispensing pharmacy on my behalf. **5)** I certify that if I have prescribed treatment for adult Growth Hormone Deficiency (GHD) it was confirmed through growth hormone stimulation testing or by other organic/clinical evidence of adult GHD (such as the lack of a pituitary gland).

Signature†‡ _____ Date _____
Print Name _____ National Provider ID (NPI) _____ DEA # _____
Address _____ City _____ State _____ ZIP _____
Office Contact _____ Phone _____ Fax _____

*Certain programs and services powered by Pfizer RxPathways®.
†This form cannot be processed without physician's signature.
‡In New York, please attach copies of all prescriptions on Official New York State Prescription forms.

Please click here for full Prescribing Information and Instructions for Use.