Skytrofa®
lonapegsomatropin-tcgd

SKYTROFA® Auto-Injector Order Form

Ocean Breeze Healthcare

Fax Form to 1-888-436-0193

(A.S.A.P.) | PO Box 158 | Jeffersonsville IN 47131 | Phone: 1-844-442-7236

This prescription is valid only if transmitted by means of a facsimile machine.

A·S·A·P
ASCENDIS SIGNATURE ACCESS PROGRAM®

*This is not a prescription for SKYTROFA prefilled cartridge.

Order Information			
Item: SKYTROFA Auto-Injector	Qty: 1	Refills: 0	Dispense as Written: N/A (no generic is available for the SKYTROFA auto-injector
Directions: Use this autoinjector with the SKYTROFA Cartridges			

Prescriber Information (Please type or print)		
Prescriber First Name:	Prescriber Last Name:	
State License Number:	NPI #	
Office Address	Suite / Unit:	
City	State	Zip
Phone:	Fax:	Office Contact:

SKYTROFA Auto Injector to be delivered to the following patient:
To allow the patient to receive status updates of their shipment, please provide the patient's mobile number and e-mail.

Patient Information and Authorization (Please type or print)			
Patient First Name:	Patient Last Name:		DOB:
Gender: ❒ Male ❒ Female ❒ Other	E-Mail: (Optional)		
Address	City	State	Zip
Mobile Phone: (Required)	Alternate Phone: (Optional)		
Caregiver Name:	Caregiver Phone:		

I certify that the information provided above is, to the best of my knowledge current, complete, and accurate and the therapy I have prescribed above is medically necessary for this patient and patient's records contain supporting documentation that substantiates the utilization and medical necessity of the therapy. I have discussed A·S·A·P with my patient and my patient would like to be screened for eligibility for A·S·A·P and provided, if applicable, any services under A·S·A·P. I will comply with my own state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language. I understand that noncompliance with state-specific requirements could result in outreach to the prescriber. I authorize the provision to patient of ancillary supplies, such as sharps containers and alcohol swabs, to administer the therapy. I acknowledge that the prescription may only be filled by a limited number of specialty pharmacies and prescriber authorizes Ascendis and those acting on its behalf to transmit the prescription electronically, by facsimile, or by mail to the appropriate dispensing specialty pharmacy.

❒ Dispense as written

Prescriber Signature (Required) _____ Date: _____

Nurse Injection Training Authorization A·S·A·P will provide my patient and/or his/her caregiver with training from a company-funded clinical nurse educator on the proper self-administration of SKYTROFA. I am requesting A·S·A·P to coordinate a nurse to provide SKYTROFA self-administration training for my patient. I will receive information on my patient's injection training via the fax number I provided above. This order is valid for 1 year.

❒ I do not wish to have my patient trained by an A·S·A·P nurse. By checking this box and opting out of nurse injection training, I acknowledge that I will assume responsibility and arrangements for SKYTROFA injection training for this patient.

You must make the clinical decision to Prescribe SKYTROFA for your appropriate patient prior to submitting this Auto-Injector Order Form.

This facsimile transmission is intended only for the recipient to which it was addressed and contains information that is confidential; the recipient is prohibited from distributing or disseminating the information contained in the transmission unless otherwise permitted by federal or other law; if the recipient is not the intended recipient or the authorized agent of the intended recipient, the recipient should immediately notify the sender by telephone and return the original message to the sender.

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