Genotropin® (somatropin [rDNA origin] for injection)

Pfizer BRIDGE PROGRAM

ADULT STATEMENT OF MEDICAL NECESSITY

PHONE: 1-800-645-1280 FAX TO: 1-800-479-2562 NUMBER OF PAGES IN FAX: _____

Reset Form

Patient Information

Patient Name (First and Last) _____ Date of Birth (DOB) _____

Address _____ Social Security Number _____

City _____ State_____ ZIP_____ Allergies ☐ None ☐ Other_____

Home Phone _____ Work Phone _____ Gender ☐ M ☐ F Primary Language _____

Referring Physician _____ Specialty _____

Insurance Information/ Attach Copy of Insurance Card

Physician Provider/Tax ID # _____ Office Contact _____

Primary Insurance _____ Secondary Insurance _____

Insurance Company Phone _____ Insurance Company Phone _____

Subscriber _____ DOB _____ Subscriber _____ DOB _____

Subscriber ID # _____ Subscriber ID # _____

Policy/Employer/Group # _____ Policy/Employer/Group # _____

Diagnosis

☐ Isolated Growth Hormone Deficiency (253.3)
☐ Iatrogenic Hypopituitarism (253.7)
- hypophysectomy-induced
- postablative
- radiotherapy-induced

☐ Panhypopituitarism (253.2)
☐ Other (specify by ICD-9 Code)
_____

Medical Assessment

Current Weight_____ lbs _____kg

Growth Hormone Stimulation Test Date _____

Agent 1 _____ Peak _____

Agent 2 _____ Peak _____

Serum IGF-I Test
Date_____ Result_____
Normal Range (Age/Sex) _____

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) — 5.8 mg ***Genotropin*** (5 mg/mL) — Pen Needle Gauge _____

☐ **B.** ***Genotropin*** PEN® 12 Growth Hormone Delivery Device (dose in increments of 0.2 mg) — 13.8 mg ***Genotropin*** (12 mg/mL) — Pen Needle Gauge _____

☐ **C.** ***Genotropin*** MIXER® Growth Hormone Reconstitution Device — Choose Cartridge: ☐ 5.8 mg ***Genotropin*** (5 mg/mL) ☐ 13.8 mg ***Genotropin*** (12 mg/mL) — Insulin Syringes ☐ 0.3 mL ☐ 0.5 mL ☐ 1.0 mL — Needle Gauge _____

☐ **D.** ***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. A 30-gauge, 5/16" injection needle is prepacked with each device. 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

Dose to Be Given Subcutaneously

Daily Dose_____ mg/day Days Supply_____ Refills____ (months) Start Date_____ Ship Product by _____

Weekly Dose_____ mg/kg/week Prescription Special Instructions_____

Special Instructions

(if applicable)

Preferred Pharmacy _____

Other _____

☐ Case Management Not Requested

☐ Patient Device Training Requested

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. (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 Pfizer Bridge 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 certify that if I have prescribed the treatment for adult Growth Hormone Deficiency (aGHD) it was confirmed through growth hormone stimulation testing or by other organic/clinical evidence of aGHD (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 _____

*This form cannot be processed without physician's signature.

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Pfizer Bridge Program™ Fax Number: **1-800-479-2562**
Pfizer Bridge Program Phone Number: **1-800-645-1280**

Documentation Required for SMN Submission

Diagnosis	History and physical	Related clinical notes	Growth chart	Growth velocity	Birth wt/ length/ gestational age	Stim test results	IGF-I/ IGF-BP3 report	Bone age X-ray report	Genetic testing report	Comment
Adult GHD	✔	✔				✔*	✔			*2 failed