Patient label here

STUDY

AUTHORIZATION FOR HUMAN GROWTH HORMONE REIMBURSEMENT

Stanford Hospital and Clinics and Lucile Packard Children's Hospital (the Hospital) understand that information about you and/your child's health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose you or your child's protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

USE(S) AND DISCLOSURE(S) COVERED BY THIS AUTHORIZATION

A representative of the Hospital must fully answer any questions you may have regarding this form. ***DO NOT SIGN A BLANK FORM****. You or your personal representative should carefully read the information below before signing this form.*

Who will disclose the information? The person(s) and/or class of persons authorized to use or disclose your information includes Stanford Hospital and Clinics, Lucile Packard Children's Hospital, Stanford School of Medicine, and their authorized agents or representatives (collectively "the Hospital").

Who will use and/or receive the information? The person(s) or class of persons authorized to receive or use your information include Genentech, and their agents, assignees and contractors, and individuals associated with Genentech, Inc.'s Single Point of Contact Program (SPOC), Genentech Access to Care Foundation (GATCF). In addition, if you choose to sign the separate authorization for the Stepping Stones Free Patient Support Program, Genentech will disclose your information to the Stepping Stones Free Patient Support Program.

What information will be used or disclosed? Contact and general demographic information for you or your child, including but not limited to name, medical record number, date of birth, address, and telephone number, and medical records for you or your child, including but not limited to all documentation that could be used to obtain authorization or reauthorization or appeal a denial form you or your child's insurance carrier.

What is the purpose of the use or disclosure? The contact and demographic information described above will be provided by the Hospital to Genentech, a company that makes and sells growth hormone(s), so Genentech may contact you regarding participating in a financial assistance program.

When will this authorization expire? This authorization will be effective, unless revoked by you in writing, until 20 years from the date this authorization is signed.

Can I revoke this authorization? You can revoke this authorization at any time before the Hospital has relied upon it, but the Hospital may use and disclose your health information to the extent that the Hospital has relied upon your authorization.

SPECIFIC UNDERSTANDINGS

By signing this authorization form, you authorize the use and disclosure of you or your child's protected health information as described above. You should note that when you or your child's protected health information is disclosed to people or entities that are not required to abide by federal or state medical privacy laws, those people or entities may re-disclose your information to others and use your information without being subject to penalties under those laws.

You understand that you have a right to refuse to sign this authorization. You and/or your child's health care, the payment for you and/or your child's health care, and you and/or your child's health care benefits will not be affected if you do not sign this form. You also have the right to revoke it at any time, except to the extent that the hospital has already taken action upon your authorization. To revoke this authorization, please write to the SHC/LPCH Privacy Office, 300 Pasteur Drive, Stanford, CA 94305-5202. You also have a right to receive a copy of this form after you have signed it.

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

CONTACT INFORMATION: The contact information of the patient or personal representative who signed this form should be filled in below.

Address:
_____
_____
_____
_____

Telephone:
_____ (daytime)
_____ (evening)

Email Address (optional):
_____

A COPY OF THIS FORM MUST BE PROVIDED TO THE PATIENT OR TO HIS OR HER PERSONAL REPRESENTATIVE AFTER IT HAS BEEN SIGNED

Nutropin AQ®
[somatropin (rDNA origin) injection]

www.SPOConline.com

Phone: **1-800-545-0498** Fax: **1-800-545-0612**
253799

FOR USE BY PATIENTS TREATED AT STANFORD HOSPITAL AND CLINICS OR LUCILE SALTER PACKARD CHILDREN'S HOSPITAL AT STANFORD ONLY

PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION

Dear Patient:
Genentech, Inc.'s Single Point of Contact (SPOC) program provides services such as benefit investigations, prior authorizations, appeals assistance at no charge to patients, and assists them in obtaining reimbursement for Genentech products. If a patient does not have insurance or is deemed uninsured due to denial by private and public payors, and the patient meets certain financial criteria, the Genentech® Access to Care Foundation (GATCF) may provide Genentech products free of charge or at a reduced rate. Additional information on this program can be found on www.SPOConline.com. In order for SPOC and GATCF to provide these services, we will need to review, use, and disclose your protected health information (PHI). By law, only with your prior written authorization may your healthcare provider, health plan, or health insurer disclose your PHI to SPOC and GATCF. You are not required to agree to this Authorization. However, failure to provide this Authorization may prevent you from becoming eligible for the SPOC reimbursement assistance program or GATCF patient assistance programs, which may result in your need to pay for certain products with your own funds. You will receive a copy of the Authorization you sign. Please review this Authorization carefully. If you have any questions regarding this Authorization, please contact your healthcare provider's office or you can contact SPOC directly at 1-800-545-0498.

AUTHORIZATION

I. INFORMATION TO BE DISCLOSED OR USED AND PERSONS AUTHORIZED TO DISCLOSE SUCH INFORMATION

This Authorization permits my healthcare providers, health plans and health insurers, and others who may hold my PHI to use and disclose to GATCF or SPOC, its authorized agents and assignees, all medical records and financial information with respect to my treatment, which may have bearing on the benefits payable for services or products provided through my healthcare provider, health plan, or insurer under any plan providing benefits or services, including, without limitation, the dollar balance of benefits remaining under any applicable lifetime maximum benefits provisions, or which may have a bearing on my medical condition or my therapy. All of this information may be considered PHI.

II. PERSONS TO WHOM DISCLOSURE MAY BE MADE

The PHI identified in Paragraph I may be disclosed to and/or used by GATCF or SPOC, their sponsor Genentech, Inc., a biopharmaceutical manufacturer located at 1 DNA Way, Mail Stop #210, South San Francisco, California 94080, their agents or assignees, and certain Genentech business partners, as well as other entities involved with the reimbursement process such as payers or independent public charities for purposes of co-pay assistance.

III. DESCRIPTION OF EACH PURPOSE

My PHI may be used for the purposes of reimbursement and/or participation in a reimbursement assistance or patient assistance program administered by SPOC and GATCF, respectively. My PHI may also be used for purposes of tracking the general use of a Genentech product, assessing and improving Genentech's reimbursement and Patient Assistance service, and proper management and administration of Genentech's business.

IV. EXPIRATION DATE OR EVENT

This Authorization will be effective, unless revoked by me in writing, for up to one year from the date of this Authorization.

V. NOTICES

I understand that once my health information is disclosed pursuant to this Authorization, there is no guarantee under federal law that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of my healthcare provider's treatment of me. If I refuse to sign or revoke this Authorization, however, I may be responsible for costs that may have otherwise been covered by GATCF or SPOC. I understand that this Authorization will remain in effect until it expires as described above or I provide a written notice of revocation to SPOC via mail at Single Point of Contact (SPOC), 1 DNA Way, Mail Stop #210, South San Francisco, CA 94080 or via Fax 1-800-545-0612. The revocation will be effective immediately upon Genentech's receipt of my written notice, except that the revocation will not have any effect on any action taken by my healthcare provider or others referenced in this Authorization, including without limitation, GATCF or SPOC, in reliance on this Authorization before my health care provider receives written notice of my revocation from Genentech.

VI. SIGNATURE

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize the use and/or disclosure of my health information in the manner described above. Further, I understand that Genentech or my healthcare provider will provide me or my personal representative a copy of the completed form after this form has been signed.

Print Patient's Name:_____

Patient/Guardian address: _____

Signature of Patient or Guardian*: _____

Description of Authority: _____ Date: _____

*If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally)

8745000

SPOC
SINGLE POINT OF CONTACT

Statement of Medical Necessity for Growth Hormone

PEDIATRIC GROWTH HORMONE TREATMENT

Phone: **1-800-545-0498** Fax: **1-800-545-0612**

PATIENT

Name (First and Last):_____ Date of Birth (MM/DD/YY):_____

Patient's Address_____

City/State/ZIP:_____ Social Security Number:_____ Male ☐ Female ☐

Primary Contact:_____ Relationship:_____

Home Ph:_____ Work Ph:_____ Cell Ph:_____

INSURANCE

Primary Insurance:_____ **Information Attached** ☐

Phone:_____ Subscriber:_____

Employer:_____ Subscriber ID :_____ Pol/Grp #:_____

Secondary Insurance:_____

Phone:_____ Subscriber:_____

Employer:_____ Subscriber ID :_____ Pol/Grp #:_____

DIAGNOSIS

Prescription Type: New Start ☐ Continued Tx ☐ Restart Tx ☐

Isolated Growth Hormone Deficiency	(253.3) ☐	Panhypopituitarism	(253.2) ☐
Iatrogenic-Induced Hypopituitarism	(253.7) ☐	Chronic Renal Failure, Chronic Uremia	(585) ☐
Turner Syndrome	(758.6) ☐	Short Stature/Growth Failure	(783.43) ☐

Other Disorder Due to Inadequacy of Endogenous Growth Hormone Secretion:_____ Specify by ICD9:_____

MEDICAL ASSESSMENT

Lab Results: (For Initial Diagnosis Only) See attached ☐

GH Stimulation Test Date:_____ Agent:_____ Peak Value:_____

GH Stimulation Test Date:_____ Agent:_____ Peak Value:_____

MRI or CT Test Results: _____

IGF-BP3 Test Results: _____

DEXA Scan Baseline: _____

Karyotype Results: _____
(Turner Syndrome Only)

Thyroid Test Results: _____

IGF-I Level: _____

Tanner Stage of Puberty: _____

GFR: _____

Ht._____cm /_____%-ile

Wt._____kg /_____%-ile

Growth Velocity:_____cm/yr

SDS Score:_____

Bone Age:_____

Date of X-ray:_____

Growth Chart Attached ☐

Clinical Impression:_____

Date Patient Last Seen:_____ **Date Therapy Initiated**:_____ **Estimated Duration**:_____

PRESCRIPTION

Injection Training to be Completed by: Office (by office staff) ☐ **X**Home (Coordinated by SPOC or Pharmacy) **Active Care** ☐

Please Dispense:

NUTROPIN AQ Pen® ☐ NUTROPIN AQ Pen® Cartridge [somatropin (rDNA origin) injection] 10 mg ☐

BD Ultra-Fine™ (original) 29 g/12.7 mm needles ☐ Other needles ☐_____

NUTROPIN AQ® [somatropin (rDNA origin) injection] 10 mg Vial ☐

NUTROPIN® [somatropin (rDNA origin) for injection] 5 mg ☐ 10 mg ☐ **Dilute**: w/_____mL

Dose:_____mg/injection (_____mL) SubQ_____inj./week Dispense:_____Months **Refill X**_____or_____PRN

Dispense:_____Syringes for Inj._____.30 cc_____.50 cc_____ 1.0 cc Other Insulin Syringe_____

Dispense: Reconstitution Syringes as Needed_____1 cc _____3 cc

STARTER RX ☐ **Date to Be Shipped**:_____ **Ship to**:_____

PRESCRIBER

Prescriber's Full Name:_____ **DEA #**:_____ **TAX I.D. #**:_____

State License #:_____ **EXP Date**:_____

Address:_____ **City/State/ZIP**:_____

Phone:_____ **Fax**:_____

I certify that the rationale for Nutropin AQ or Nutropin therapy is for growth failure due to lack of endogenous growth hormone secretion, chronic renal insufficiency up to the time of renal transplantation, the long-term treatment of short stature associated with Turner Syndrome or idiopathic short stature (non-growth hormone-deficient short stature) and I will be supervising the patient's treatment accordingly.

By signing below, I certify that (a) the above therapy is medically necessary, (b) I have received the necessary authorization to release the above referenced information and other protected health information (as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA)) to Genentech's Single Point of Contact program (SPOC) and contracted dispensing pharmacy or other contractors for the purpose of seeking reimbursement, assisting in initiating or continuing therapy, and/or the evaluation of the patient's eligibility for the Genentech Access To Care program related to Genentech products, and © I appoint SPOC solely to convey on my behalf to the pharmacy chosen by the above-named patient the prescription described herein.

Prescriber's Signature*:_____ **Date**:_____

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

Nutropin AQ®
[somatropin (rDNA origin) injection]

www.SPOConline.com

Phone: **1-800-545-0498** Fax: **1-800-545-0612**

STEPPING STONES FREE PATIENT SUPPORT PROGRAM

I authorize Genentech, Inc. to enroll me/my child in a free patient support program. I understand my name, address, e-mail address, phone number and the name of my pharmacy, once identified, will be sent by SPOC to the free patient support program to complete my enrollment. I agree that Genentech and its agents may contact me in the future by mail, e-mail, and/or telephone concerning the free patient support program. I understand that all personally identifiable information will be kept strictly confidential and will not be distributed outside of Genentech or its agents, as the Genentech, Inc. privacy policy provides (available at www.steppingstones.nutropin.com). I also understand that I do not have to sign this authorization in order to receive Nutropin or participate in the SPOC/GATCF program and that I may cancel this authorization at any time by giving written notice to Genentech/Nutropin through its agent at PO Box 29478, Mission, KS 66201-9907.

Print Patient's Name

Name _____

Patient/Guardian address _____

Description of Authority _____

E-mail Address: _____

SIGNATURE OF PATIENT/GUARDIAN*: _____

Date: _____

**If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally)*

SteppingStones™