Genotropin® (somatropin) for injection

Pfizer Bridge Program® Enrollment Form

HOW TO COMPLETE

Color Coding Guide

Color coding indicates which pages of the form should be completed by the patient or healthcare provider (HCP).

HCP TO COMPLETE

- ☐ **All sections of pages 1 and 2 must be completed, with the exception of the Special Instructions box**
- ☐ **Special Instructions**
  - See below for a description of the different support and program options that may be selected for the patient being prescribed GENOTROPIN
- ☐ **When selecting a device, please make sure to select the dose and pen needle gauge**
- ☐ **Provide page 3 to the patient for them to complete and sign**
  - Add the signed Patient Authorization to their file

SPECIAL INSTRUCTIONS (Patient signature may be required to discuss some or all of these patient services)

- **Benefit Verification ONLY:** If a BV is requested, the Patient Care Coordinator can investigate insurance coverage for patients and will reach out to review and help them understand coverage options.
- **Device Training Requested:** A qualified nurse will provide a one-time one-on-one training on how to inject, as well as guidance on getting accustomed to therapy and setting up a routine.
- **GENOTROPIN Copay Program*:** Eligible patients may pay as little as $0 per prescription through the copay program. Click here for terms and conditions.
- **Request Pen Device ONLY:** Use this box if you are only requesting a new device for the patient.
- **Interim Care†:** Eligible, commercially insured patients may be able to receive free medication for up to three months while they await reauthorization or appeals outcome.

PATIENT TO COMPLETE

By enrolling in the Pfizer Bridge Program, patients will receive various support and information to help access GENOTROPIN, which may include the following, depending on the program (collectively, "Patient Support Activities"):

- Providing benefits verification and reimbursement support, including:
  - Assisting with identification of the patient's insurer's prior authorization requirements
  - Assisting with identification of the patient's insurer's requirements for appealing a denied claim
- Determining eligibility for and helping eligible patients access copay support or free drug programs
- Sending the patient a device and starter kit (where appropriate)
- Communicating with the patient's Healthcare Providers about GENOTROPIN and Patient Support Activities
- Providing the patient with financial assistance resources and information, if eligible
- Providing the patient with disease management and other educational materials, as well as information about Pfizer's products, services, and programs, and may include sending the patient surveys about their experience with Pfizer products, services, and programs

For enrollment into the Pfizer Patient Assistance Program or Drug Replacement Program call the Pfizer Bridge Program at 1-800-645-1280.

Fax completed forms to the Pfizer Bridge Program at 1-800-479-2562

OR

Mail to PO Box 220746, Charlotte, NC 28222

You may access additional forms at www.PfizerBridgeProgram.com.

*Eligibility required. Annual savings up to $5,000. State and federal health care program beneficiaries not eligible even if they elect to be processed as an uninsured (cash-paying) patient. Terms and conditions apply. The savings program is not health insurance. No membership fees. Pfizer reserves the right to rescind, revoke or amend this offer without notice. Offer expires 12/31/2020. For more information, visit our website www.genotropin.com, call 1-800-645-1280 or visit Pfizer.com. Genotropin Savings Program, PO Box 220746, Charlotte, NC 28222-0746. Click here for terms and conditions.

†Interim Care must be requested by the HCP. Patients must meet program criteria to receive the support. Interim care support duration is for a maximum of 90 days. Requests for assistance beyond 90 days are evaluated on a case-by-case basis. For FDA-approved indications only. Commercially insured patients only and may not reside in MA, MI, MN, MO, OH, or RI. Pfizer reserves the right to discontinue assistance through the Interim Care program at any time.

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For assistance or additional information, call 1-800-645-1280, Monday – Friday, 9 AM – 7 PM ET.

TO BE COMPLETED BY HCP

SPECIAL INSTRUCTIONS

☐ Benefits Verification ONLY ☐ Device Training Requested ☐ GENOTROPIN Copay Program

☐ Request Pen Device ONLY ☐ Interim Care Rx Requested ☐ Other _____

❶ Patient Information

First Name _____ Middle Initial _____ Last Name _____

DOB (mm/dd/yyyy) _____ Gender: ☐ M ☐ F Parent/Guardian Name _____

Address _____ City _____ State _____ ZIP Code _____

Primary Phone _____ ☐ H ☐ W ☐ M Alternate Phone _____ ☐ H ☐ W ☐ M

Email _____ Preferred Language (if not English) _____

Caregiver Name _____ Caregiver Phone _____ ☐ H ☐ W ☐ M

Caregiver Email _____

❷ Insurance Information

☐ **INSURANCE CARD(S) ATTACHED** ☐ **CHECK IF PATIENT DOES NOT HAVE PRESCRIPTION COVERAGE** ☐ **CHECK IF PATIENT HAS SECONDARY PRESCRIPTION COVERAGE**

Primary Insurance _____ Insurance Phone _____

Policy ID # _____ Group # _____

Policy Holder Name (First, Last), DOB, and Relationship to Patient _____

Prescription Drug Insurer _____ Phone _____

Policy ID # _____ Group # _____

Rx BIN # _____ Rx PCN # _____

Patient's Preferred Pharmacy _____ ☐ Self-Dispensing Pharmacy

The patient identified above prefers use of the pharmacy indicated above. I authorize Pfizer and its affiliates, agents, representatives and service providers to fax this prescription to the pharmacy designated above, provided it is approved by this patient's plan. If the pharmacy designated is not a plan-approved pharmacy, then to a pharmacy approved by this patient's plan. If there is no preferred pharmacy indicated, then to any pharmacy approved by this patient's plan.

❸ Prescriber Information *Required field

*Prescriber First Name _____ *Prescriber Last Name _____ Prescriber NPI # _____

*Specialty _____ Group Tax ID # _____ State License # _____

*Practice Name _____ Office Contact _____

*Address _____ *City _____ *State _____ *ZIP Code _____

*Phone _____ Fax _____

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TO BE COMPLETED BY HCP

Patient Full Name _____ Patient DOB (mm/dd/yyyy) _____

❹ Diagnosis

DO NOT ATTACH ANY CLINICAL OR OFFICE NOTES AS THIS MAY DELAY PROCESSING THE FORM

- ☐ Hypopituitarism (includes isolated GHD and panhypopituitarism) (E23.0)
- ☐ Postprocedural hypopituitarism (E89.3)
- ☐ Hypopituitarism iatrogenic NEC (E23.1)
- ☐ Newborn, small for gestational age (P05. _____)
- ☐ 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) _____

❺ Device Options

A ☐ **GENOTROPIN Pen® 5**
Growth Hormone Delivery Device
☐ 5 mg GENOTROPIN (5 mg/mL)

Pen Needle Gauge
☐ 29 ☐ 31 (dose in increments of 0.1 mg)

B ☐ **GENOTROPIN Pen® 12**
Growth Hormone Delivery Device
☐ 12 mg GENOTROPIN (12 mg/mL)

Pen Needle Gauge
☐ 29 ☐ 31 (dose in increments of 0.2 mg)

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

❻ Dose

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

❼ Healthcare Provider Consent

This form cannot be processed without healthcare provider's signature

I certify that I am the healthcare professional who has prescribed the therapy identified in this form. I further certify that I have made an independent judgment that the above therapy is medically necessary and that the information provided in this form is accurate to the best of my knowledge. I further 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). I further certify that any support 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. I authorize Pfizer, and its affiliates, agents, representatives and service providers to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

SIGN _____ _____

Doctor/Prescriber Signature: NO STAMPS **(Dispense as Written)** Date

If you are a New York prescriber, please use an Original New York State Prescription form.

❽ Healthcare Provider HIPAA and TCPA Attestation

This form cannot be processed without healthcare provider's signature

By my signature, I certify that I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Pfizer and its employees or agents for purposes relating to Pfizer's patient support programs, including, assisting the patient with benefits verification, prior authorization/appeals assistance, financial assistance resources and information, such as copay support or free drug programs, for which the patient may be eligible, and other support for GENOTROPIN.

I certify that I have obtained consent from the patient or the patient's caregiver to be contacted by Pfizer, the Pfizer Bridge Program, and/or parties acting on their behalf using an autodialer or prerecorded voice at the telephone number(s) provided regarding the purposes described above and for other non-marketing purposes. I also give my permission to receive calls related to these services from Pfizer, the Pfizer Bridge Program, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

SIGN _____ _____

Doctor/Prescriber Signature Date

Patient Authorization to Share Health Information and Receive Communications

TO BE COMPLETED BY PATIENT

By signing this form, I give my permission for my physicians, pharmacies, laboratories, and other healthcare providers ("Healthcare Providers") and my health insurers to share my health information with Pfizer Inc., the Pfizer Patient Assistance Foundation, Pfizer affiliates and its vendors (collectively, "Pfizer"). I understand that my health information includes information relating to my medical condition, treatment, and insurance coverage, as well as identifying information about me (including, for example, my name, address, and date of birth). My health information will be shared with Pfizer so that Pfizer may provide me with various support and information to help me access a Pfizer medicine, which may include the following, depending on your program (collectively, "Patient Support Activities"):

- Providing benefits verification and reimbursement support, including:
  - Assisting with identification of my insurer's prior authorization requirements
  - Assisting with identification of my insurer's requirements for appealing a denied claim
- Determining my eligibility for and helping me access copay support or free drug programs
- Sending me a device and starter kit (where appropriate)
- Communicating with my Healthcare Providers about a Pfizer medicine and Patient Support Activities
- Providing me with financial assistance resources and information if I'm eligible
- Providing me with disease management and other educational materials, as well as information about Pfizer's products, services, and programs, and may include sending me surveys about my experience with Pfizer products, services, and programs

Pfizer also may use my health information for quality assurance purposes and to evaluate and improve our operations and services.

I understand that I do not have to sign this form, and choosing not to sign will not affect my ability to receive treatment from my Healthcare Providers or payment from my health insurer. However, if I do not sign this form, The Pfizer Bridge Program® may not be able to provide me with assistance.

I understand that once my health information is shared, it may no longer be protected by federal privacy law. However, Pfizer agrees to protect my health information and to use it for the purposes described in this form or as required or permitted by law. Select pharmacies may receive remuneration from Pfizer in exchange for my health information and/or for any Patient Support Activities provided to me.

I understand that this form will remain in effect for 4 years from the date of my signature unless I provide written notice that I would like to withdraw my approval to share my health information sooner. If I would like to withdraw my approval, I may contact my physician, or I may contact The Pfizer Bridge Program at 1-800-645-1280 or PO Box 220746, Charlotte, NC 28222. This withdrawal will not affect the use or sharing of my health information that took place before I withdraw my approval. I understand I may receive a copy of this form.

I also give my permission to receive communications from Pfizer, The Pfizer Bridge Program, and parties acting on their behalf, including text messages or calls made with an autodialer or prerecorded voice at the phone number(s) provided to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, and financial assistance resources and information, such as copay support or free drug programs, and for other non-marketing purposes. If I have a caregiver, he or she has also agreed to receive such communications from Pfizer, The Pfizer Bridge Program, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, The Pfizer Bridge Program, and/or parties acting on their behalf to contact my caregiver for such purposes. I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting The Pfizer Bridge Program at 1-800-645-1280.

Patient Name _____ Date _____

SIGN

Signature: Patient/Certification of person legally authorized to sign for patient _____ Relationship _____