GENENTECH PATIENT FOUNDATION

Prescriber Foundation Form for Nutropin

Prescriber to Complete

GenentechPatientFoundation.com
Nutropin GPS: (866) 688-7674
Fax: (800) 545-0612
Hours: 9 a.m.–5 p.m. (EST) M-F
*Required field M-US-00000058(v6.0)

Who is eligible?

The Genentech Patient Foundation gives free medicine to people who are:

Uninsured
With income under $150,000

OR

Insured Without Coverage for a Genentech medicine†
With income under $150,000

OR

Insured With Coverage for a Genentech medicine‡
- With unaffordable out-of-pocket costs
- With household size and income within the guidelines listed to the right

For all patient types, add $25,000 for each extra person in households larger than 4 people.

If none of the ***three situations*** apply or you are unsure of your insurance coverage, Nutropin GPS™ Program can help. Nutropin GPS™ Program is a program from Genentech committed to helping you understand your insurance coverage and options that might be able to help you pay for your Genentech medicine.
Call **(866) 688-7674** for more information.

Household Size	Annual Income
1	Less than $75,000
2	Less than $100,000
3	Less than $125,000
4	Less than $150,000

How to apply

1. **Prescriber** completes Pages 1 and 2 of the Prescriber Foundation Form
2. **Patient** completes Patient Consent Form (Boxes 1 and 2 required)
3. Fax both completed forms to **(800) 545-0612**

What to expect after applying? Once an eligibility determination has been made, both the patient and prescriber will be contacted to discuss the application outcome and any next steps.

Step 1 Patient Eligibility

*Please check one (refer to page 1 for details on each type):

☐ Uninsured
☐ Insured but lacks coverage for this medicine
☐ Insured with coverage but medicine is unaffordable

For insurance denials, provide denial date: ____/____/_____
Denial reason (or attach copy of denial letter): _____

If unsure of patient's insurance status, please contact Nutropin GPS™ Program at (866) 688-7674.

Step 2 Patient Information

*First Name: _____ *Last Name: _____
*Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female
*Street: _____ Apt: _____
*City: _____ *State: _____ *ZIP: _____
Phone: (_____) _____-_____ Phone Type: ☐ Cell ☐ Home
Preferred Language: ☐ English ☐ Spanish ☐ Other: _____
☐ Do not contact patient Alternate Contact: _____
Relationship to patient: _____
Alt Contact Phone: (_____) _____-_____ Phone Type: ☐ Cell ☐ Home

Step 3 Treatment Information

Genentech Medication: Nutropin AQ Has Patient Started Therapy? ☐ Yes ☐ No

*ICD-10-CM codes: Please check the appropriate diagnosis code for which this medication is being prescribed.

Category	Code	Description
Adult Growth Hormone Treatment	☐ E23.0	Hypopituitarism
	☐ E23.3	Drug-induced hypopituitarism
	☐ E23.7	Hypothalamic dysfunction, not elsewhere classified
	☐ E34.30	Short stature due to endocrine disorder, unspecified
	☐ E34.328	Other genetic causes of short stature
	☐ E34.39	Other short stature due to endocrine disorder
	☐ E89.3	Postprocedural hypopituitarism
Pediatric Growth Hormone Treatment	☐ E23.0	Hypopituitarism
	☐ E23.3	Hypothalamic dysfunction, not elsewhere classified
	☐ E23.7	Disorder of pituitary gland, unspecified
	☐ E34.30	Short stature due to endocrine disorder, unspecified
	☐ E34.328	Other genetic causes of short stature
	☐ E34.39	Other short stature due to endocrine disorder
	☐ E89.3	Postprocedural hypopituitarism
	☐ R62.52	Short stature (child)
	☐ Q96.0	Turner's syndrome, karyotype 45, X
	☐ Q96.1	Turner's syndrome, karyotype 46, X iso (Xq)
Pediatric Growth Hormone Treatment (cont)	☐ Q96.2	Turner's syndrome, karyotype 46, X with abnormal sex chromosome, except iso (Xq)
	☐ Q96.3	Turner's syndrome, mosaicism, 45, X/46, XX or XY
	☐ Q96.4	Turner's syndrome, mosaicism, 45, X/other cell line(s) with abnormal sex chromosome
	☐ Q96.8	Other variants of Turner's syndrome
	☐ Q96.9	Turner's syndrome, unspecified
Pediatric Nephrology Hormone Treatment	☐ N18.1	Chronic kidney disease, stage 1
	☐ N18.2	Chronic kidney disease, stage 2 (mild)
	☐ N18.30	Chronic kidney disease, stage 3 unspecified
	☐ N18.31	Chronic kidney disease, stage 3a
	☐ N18.32	Chronic kidney disease, stage 3b
	☐ N18.4	Chronic kidney disease, stage 4 (severe)
	☐ N18.5	Chronic kidney disease, stage 5
	☐ N18.6	End stage renal disease
	☐ N18.9	Chronic kidney disease, unspecified

☐ Other _____

ICD-10-CM=International Classification of Diseases, 10th Revision, Clinical Modification. †The Genentech Patient Foundation does not provide free medicine in the instance of an administrative error or a coverage restriction such as a step edit. Some exceptions may apply. ‡We encourage insured patients to pursue other financial assistance options prior to applying for help from the Genentech Patient Foundation, if possible Genentech reserves the right to modify or discontinue the program at any time and to verify the accuracy of information submitted.

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Step 4 Patient Information (please re-enter)

*First Name: _____ *Last Name: _____ *Date of Birth: ____/____/_____

*Street: _____ Apt: _____

*City: _____ *State: _____ *ZIP: _____

Step 5 Insurance Information If patient has ANY insurance, complete this section or attach copies of insurance card(s).

	Primary Insurance	Secondary Insurance	Pharmacy Benefit
Insurance name			
Type (Comm, Medicare, Medicaid)			
Subscriber name (if not patient)			
Subscriber/Policy ID #			
Group #			
Insurance phone			
Maximum out of pocket			

Step 6 Prescription Information

Device/Product	Needles	Quantity
☐ NuSpin® 20 (0.2 mg dosing increments) ☐ NuSpin® 10 (0.1 mg dosing increments) ☐ NuSpin® 5 (0.05 mg dosing increments)	☐ BD Ultra-Fine™ III Short Pen Needle 31 G/8 mm (default if no needle is selected) ☐ BD Ultra-Fine™ 29 G/12.7 mm ☐ NovoFine® Autocover® 30 G/8 mm ☐ Other: _____	Dose: _____ mg/inj SubQ: _____ inj/week Dispense: _____ month supply Refill: × _____ Recommended dose for chronic kidney disease (CKD) is 0.35 mg/kg/week divided into daily doses.

Patient Weight: _____ Drug Allergies: ☐ No Known ☐ Other: _____

Other Medications Prescribed: _____

Step 7 Prescriber Information

Prescriber specialty: Genentech Patient Foundation will be limited to health care providers (HCPs) licensed to prescribe in Endocrinology or Nephrology.

*First Name: _____ *Last Name: _____

*Practice Name: _____ *Specialty: _____ ☐ *Adult ☐ *Pediatric

*Street: _____ Suite: _____

*City: _____ *State: _____ *ZIP: _____ *Prescriber NPI† #: _____

Office Contact Name: _____ Contact Phone: (_____) _____-_____ Contact Fax: (_____) _____-_____

If you are a resident of a US state that provides certain rights with respect to your personal information, a complete description of the personal information we may collect and process, the purposes for which it is used by Genentech, and your rights under your state's privacy laws concerning your personal information can be found in our privacy notice at www.gene.com/privacy-policy.

Step 8 Health Care Provider Certification

By signing below, I certify that I am prescribing Nutropin therapy for the patient named above and that (A) the above therapy is medically necessary and that I will supervise the patient's treatment accordingly, **(B)** I have performed the necessary tests to arrive at the diagnosis code above, **(C)** I am not prescribing Nutropin AQ for any of the following purposes: (1) athletic performance, (2) athletic body building, (3) anti-aging or (4) cosmetic use, and **(D)** any dosing changes will not exceed the calculated maximum dose per the approved label. **Genentech will only provide Nutropin AQ if it is being prescribed for an indication that is listed in the FDA approved label for Nutropin or another FDA approved human growth hormone in the United States.**

By signing below, I am agreeing to the following: (A) The Genentech medicine listed above is medically necessary for this patient and the treatment decision has been made by me as the prescribing physician. **(B)** I have received the necessary authorizations, including those required by state law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to release the above-referenced information and other health and medical information of the patient to Genentech, Inc., its agents and the contracted dispensing pharmacy, for the purpose of requesting reimbursement support, assisting in initiating or continuing therapy and/or the evaluation of the patient's eligibility for Genentech Patient Foundation, or for necessary legal or compliance purposes. **(C)** I will not seek reimbursement for free product provided to the patient. **(D)** My patient meets the criteria for the Genentech Patient Foundation and to the best of my knowledge, this patient has no prescription insurance coverage (including Medicaid, Medicare, or other public or private programs) for the Genentech medicine listed above, or is unable to afford the cost-sharing requirements associated with his/her insurance coverage for this medication. If the patient is enrolled in an insurance plan, the plan does not require the patient's application to the Genentech Patient Foundation and/or has not changed or hidden the patient's coverage for the Genentech medicine to make them appear to be underinsured and eligible for the Genentech Patient Foundation. **(E)** I understand that Genentech reserves the right to modify or discontinue the program at any time and to verify the accuracy of information submitted. **(F)** For insured patients, I understand that the Genentech Patient Foundation does not provide free drug in the instance of an administrative error or a coverage restriction such as a step edit. For certain products where the step edit may not be medically appropriate, as confirmed by the prescribing physician, the Genentech Patient Foundation may consider support following 1 level of appeal. **(G)** I request Genentech, Inc., and its agents to convey to the pharmacy chosen by the above-named patient the prescription prescribed herein, where applicable. **(H)** For prescribers in states with official prescription form requirements, such as New York, prescriptions must be submitted on an official state prescription pad along with this enrollment form.

Sign, date & fax to (800) 545-0612

*Health Care Provider Signature: _____ *Date: ____/____/_____

(Original signature required)

†National Provider Identifier.