Statement of Medical Necessity

Phone: 888-NOVO-444
Fax: 888-508-8200

nordicare® Comprehensive Support Services

○ New referral ○ Patient has been provided sample product Patient transitioning from ☐ Trial product ☐ Other product

Patient Information

Patient name: _____ DOB: _____ Patient SSN: _____
Parent name: _____ Address: _____
City: _____ State/ZIP: _____
Home phone: _____ Work phone: _____ Cell phone: _____
○ Male ○ Female ○ Pediatric ○ Adult Allergies: ○ None ○ List _____

Patient Authorization and Release

I understand that Novo Nordisk, its personnel, and/or agents including RxCrossroads, LLC (collectively, NordiCare®) must use, share, and store my personal health information in order to help me gain reimbursement coverage for and begin Norditropin® therapy (including, if requested, product demonstration by a NordiCare® representative). I hereby authorize NordiCare® to contact my healthcare provider, insurance company, or other third-party payers, and for such parties to give NordiCare® all necessary medical records and payer information. This authorization expires on December 31, 2015, unless I notify both my healthcare provider and NordiCare® (at fax number 888-508-8200) in writing that I withdraw my approval to share my health information. I understand that once my health information is released to NordiCare®, it is no longer protected by federal law but that NordiCare® will protect such information and use it only for the purposes stated above.

_____ _____
Signature of Patient or Legal Representative (Parent or Guardian) **Date**

☐ Please check here if you would like to receive future offers and communications from Novo Nordisk. Please provide your e-mail address. _____

Insurance Information (Attach Copy of Insurance Card)

Primary insurance: _____ Secondary insurance: _____
Phone: _____ Phone: _____
Subscriber name: _____ Subscriber name: _____
Subscriber ID #: _____ Subscriber ID #: _____
Policy/Group #: _____ Policy/Group #: _____

Diagnosis

○ **Childhood-onset GHD** ☐ Isolated GHD (253.3) ☐ Benign pituitary tumor (227.3) ☐ Other (ICD-9): _____
○ **Adult-onset GHD** ☐ Panhypopituitarism (253.2) ☐ Craniopharyngioma (237.0)
☐ Iatrogenic pituitary disorder (253.7)

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Attach (if applicable):
☐ Patient's growth chart
☐ Clinical notes/history
☐ Test results (Stim test and labs: x-ray, MRI, IGF-1, IGFBP3)

Date: _____ Height: ____ (cm) ____ % Weight: ____ (kg) ____ % Growth velocity: _____ (cm/y)
Date: _____ IGF-1: _____ SDS: _____ IGFBP3: _____
Date: _____ Bone age: _____ Chronological age: _____ ○ Open epiphysis ○ Closed epiphysis
Mother's height: _____ (cm) Father's height: _____ (cm)
Stim test date: _____ Stim test agent #1: _____ Peak value: _____ Units: _____
Stim test agent #2: _____ Peak value: _____ Units: _____

Prescription

Physician name: _____ DEA #: _____ License #: _____ Tax ID #: _____
Practice name (office contact): _____ Address: _____
City: _____ State/ZIP: _____ Phone: _____ Fax: _____

○ Yes ○ No **Register patient** with NordiCare® only (no insurance verification or training needed).
○ Yes ○ No **Ship Starter Kit:** Appropriate kit will be sent for prescribed delivery system, disposable needles, and allied injection materials. ☐ **Spanish Material**
○ Yes ○ No **JumpStart request:** The patient and I agree that, if qualified, a JumpStart shipment should be sent prior to completion of insurance verification so that patient may receive Norditropin® by _____ (date). Shipping schedule to be confirmed with patient by NordiCare®.
○ Yes ○ No **Initiate insurance verification** by NordiCare®.
○ Yes ○ No **Initiate training** by NordiCare®: ☐ Home ☐ Office Comments: _____

Norditropin NordiFlex®: (disposable pen device)
☐ 5 mg/1.5 mL (NDC 0169-7704-11)
☐ 10 mg/1.5 mL (NDC 0169-7705-11)
☐ 15 mg/1.5 mL (NDC 0169-7708-11)

Norditropin® cartridge: (reusable pen device)
☐ 5 mg/1.5 mL cartridge with NordiPen® 5 delivery system (NDC 0169-7768-11)
☐ 15 mg/1.5 mL cartridge with NordiPen® 15 delivery system (NDC 0169-7770-11)

NovoFine® needles:
☐ 31 G disposable needles _____ box(es) of 100 (NDC 0169-1852-55)
☐ 30 G disposable needles _____ box(es) of 100 (NDC 0169-1852-50)
☐ 30 G Autocover® disposable safety needles _____ box(es) of 100 (NDC 0169-1852-75)

Dose

Daily dose: _____ mg/day
Dose frequency: _____ sc injections/week
Refills: _____

Please remember to indicate the quantity and type (31 G or 30 G) of needles that should be shipped to the patient.

Preferred pharmacy (optional): _____
Other requirements: _____

Physician Authorization and Release

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By my signature I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required for Novo Nordisk, its employees or agents, including RxCrossroads, LLC (collectively, "NordiCare®"), to assist in obtaining coverage for Novo Nordisk human growth hormone products and to assist in initiating or continuing Novo Nordisk therapy.

_____ _____
Physician signature (dispense as written, no signature stamps) Date

novo nordisk®

Please see enclosed Prescribing Information.

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Novo Nordisk Inc., 100 College Road West, Princeton, New Jersey 08540 U.S.A.

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norditropin® *somatropin (rDNA origin) injection*