

PATIENT ENROLLMENT FORM—PEDIATRIC

Please select your patient's growth hormone (GH) treatment experience*: ☐ New to GH therapy ☐ Continuing on SKYTROFA (lonapegsomatropin-tcgd) ☐ Switching from previous therapy: _____			
☐ SKYTROFA FastStart ☐ Reimbursement support ☐ SKYTROFA Auto-Injector only†			
1-PATIENT INFORMATION/ AUTHORIZATION	Patient name*: _____ Date of birth*: __/__/____ Sex*: ☐ M ☐ F Address*: _____ City*: _____ State*: ____ ZIP*: _____ Primary language: _____	Parent/Guardian #1: Name*: _____ Relationship to patient*: _____ Phone*: (____) ____-____ Email: _____	Parent/Guardian #2: Name: _____ Relationship to patient: _____ Phone: (____) ____-____ Email: _____
	☐ Copies of front and back of primary medical insurance and pharmacy insurance (if applicable) cards are attached ☐ Patient has pharmacy insurance ☐ Patient is not insured		
	Primary medical insurance*: _____ Pharmacy/Rx insurance: _____ Member ID #: _____ Group ID #: _____ Member name: _____ Phone: (____) ____-____		
	Prior authorization (PA) submitted: ☐ Yes ☐ No PA approval: ☐ Yes ☐ No Date of PA approval: __/__/____ Reference number: _____		
Please check the applicable ICD-10 diagnosis code. Pediatric GH deficiency (GHD)*: ☐ E23.0 Isolated GH deficiency ☐ E23.0 Idiopathic GH deficiency ☐ E23.1 Drug-induced hypopituitarism ☐ E23.0 Hypopituitarism ☐ E89.3 Postprocedural hypopituitarism ☐ E23.0 Panhypopituitarism ☐ Other ICD-10 code: _____			
4-MEDICAL ASSESSMENT	Current weight*: _____ kg Weight SDS: _____ Current height: _____ cm Height SDS: _____ Growth velocity: _____ cm/yr	Date of GH stimulation test: __/__/____ Agent 1: _____ Peak level: _____ ng/mL Agent 2: _____ Peak level: _____ ng/mL Date of bone age X-ray: __/__/____ Bone age: _____ Chronological age: _____	Date of IGF-1 test: __/__/____ Results: _____ IGF-1 SDS: _____ MRI (pituitary gland) completed: ☐ Yes ☐ No ☐ Not applicable
	SKYTROFA cartridge strengths for use with SKYTROFA Auto-Injector (please select one)*: Inject 1 cartridge subcutaneously per weekly dose of: ☐ 3 mg: (NDC 73362-003-01) 11.5–13.9 kg ☐ 3.6 mg: (NDC 73362-004-01) 14.0–16.4 kg ☐ 4.3 mg: (NDC 73362-005-01) 16.5–19.9 kg ☐ 5.2 mg: (NDC 73362-006-01) 20.0–23.9 kg ☐ 6.3 mg: (NDC 73362-007-01) 24.0–28.9 kg ☐ 7.6 mg: (NDC 73362-008-01) 29.0–34.9 kg ☐ 9.1 mg: (NDC 73362-009-01) 35.0–41.9 kg ☐ 11 mg: (NDC 73362-010-01) 42.0–50.9 kg ☐ 13.3 mg: (NDC 73362-011-01) 51.0–60.4 kg ☐ _____ Inject 2 cartridges subcutaneously per weekly dose of (for patients ≥ 60.5 kg): ☐ 7.6 mg: (NDC 73362-008-01) 60.5–69.9 kg ☐ 9.1 mg: (NDC 73362-009-01) 70.0–84.9 kg ☐ 11 mg: (NDC 73362-010-01) 85.0–100.0 kg ☐ _____ Month(s) supply: _____ Refills: _____ The SKYTROFA Auto-Injector is packaged in a separate carton.		
5-PRESCRIPTION/DOSAGE	☐ CVS ☐ Optum ☐ Lumicera ☐ Accredo ☐ Walgreens Specialty Pharmacy ☐ Other: _____		
6-PRESCRIBER INFORMATION	Prescriber name*: _____ Practice*: _____ DEA #: _____ Prescriber Tax ID #: _____	Prescriber NPI #: _____ Address*: _____ City*: _____ State*: _____ ZIP*: _____	Office contact*: _____ Office contact phone*: (____) ____-____ Office contact fax*: (____) ____-____ Office contact email*: _____
	I certify that the information provided above is, to the best of my knowledge current, complete, and accurate and the therapy I have prescribed above is medically necessary for this patient and patient's records contain supporting documentation that substantiates the utilization and medical necessity of the therapy. I have discussed A-S-A-P with my patient and my patient would like to be screened for eligibility for A-S-A-P and provided, if applicable, any services under A-S-A-P. I will comply with my own state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language. I understand that noncompliance with state-specific requirements could result in outreach to the prescriber. I authorize the provision to patient of ancillary supplies, such as sharps containers and alcohol swabs, to administer the therapy. I acknowledge that the prescription may only be filled by a limited number of specialty pharmacies and prescriber authorizes Ascendis and those acting on its behalf to transmit the prescription electronically, by facsimile, or by mail to the appropriate dispensing specialty pharmacy.		
7-PRESCRIBER AUTHORIZATION	☐ Dispense as written Prescriber signature*: _____ Date: __/__/____		
	☐ Substitution allowed Prescriber signature*: _____ Date: __/__/____		
8-TRAINING AUTHORIZATION	Nurse Injection Training Authorization A-S-A-P will provide my patient and/or his/her caregiver with training from a company-funded clinical nurse educator on the proper self-administration of SKYTROFA. I am requesting A-S-A-P to coordinate a nurse to provide SKYTROFA self-administration training for my patient. I will receive information on my patient's injection training via the fax number I provided above. This order is valid for 1 year.		
	☐ I do not wish to have my patient trained by an A-S-A-P nurse. By checking this box and opting out of nurse injection training, I acknowledge that I will assume responsibility and arrangements for SKYTROFA injection training for this patient.		

For auto-injector only, please complete sections 1, 2, 3, 5, 6, and 7.

†For auto-injector only, must include evidence of an approved claim by insurance.

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