Macrilen™ (macimorelin) for oral solution

Service and Prescription Request Form

If you have questions, please call
1-844-MAC-AGHD (1-844-622-2443)

Please fax form to 1-844-622-7771

SERVICES REQUESTED FOR MACRILEN™ (Please check all that apply)

❑ **Benefit verification:** Office will receive a summary for both the medical and pharmacy benefits, including co-pay eligibility and enrollment.

❑ **Coordination of Specialty Pharmacy fulfillment:** Upon coverage determination, your office will be notified which Specialty Pharmacy is fulfilling the prescription based on your patient's benefit plan. The Specialty Pharmacy will contact your office to coordinate shipping.

PATIENT INFORMATION

First name:	Last name:	Middle initial:	
DOB (MM/DD/YYYY):	Address:		
Gender: ❑ Male ❑ Female	City:	State:	Zip code:
Home phone #:	Cell phone #:		

INSURANCE INFORMATION (Please attach copies of both insurance cards [primary and secondary] or provide information below)

❑ Check here if the patient does not have insurance.

Medical insurance company:	Member ID #:	Group ID #:
Insurance phone #:	BIN:	
Medical group (IPA):		
Pharmacy benefit plan:	Member ID #:	Group ID #:
Insurance phone #:	BIN:	
Person code #:	PCN:	

PRESCRIBER INFORMATION

Prescriber's first name:	Prescriber's last name:		
NPI #:	Tax ID #:	Medicaid/Medicare PTAN:	
Practice name:	Phone #:	Fax #:	
Practice address:	City:	State:	Zip code:
Reimbursement/Clinical contact name:	Email:		
Site of administration (select one):	❑ Physician's office	❑ Hospital outpatient	❑ Alternate site
Shipping address (if different from practice address listed above):			
City:	State:	Zip code:	

PRESCRIBER CERTIFICATION

My signature below certifies that the person named on this form is my patient and that I have obtained his/her written authorization in accordance with applicable state and federal laws, including the Health Insurance Portability and Accountability Act of 1996 and its implemented regulations, to provide the individually identifiable health information on this form to reimbursement support programs and its agents, contractors, representatives, and affiliates for purposes of conducting an investigation of my patient's health insurance coverage benefits for Macrilen™. This also authorizes CareConnection to reach out to my patient 1 time for logistics regarding the Macrilen™ test.

Prescriber's signature: ______________________ Date: ____________

PRESCRIPTION INFORMATION

Rx: Macrilen™ (macimorelin) for oral solution		SIG: Administer as a 1-time, single, oral dose of 0.5 mg/kg.	
❑ ICD-10/Diagnosis code: E34.9 ❑ ICD-10/Diagnosis code: E23.0 ❑ Other: ____________ Patient weight: ________ kg Note: 2.2 lb=1 kg	Quantity dispensed: ❑ 1 pouch (60 mg granules) (for patients weighing ≤120 kg) ❑ 2 pouches (60 mg granules) (for patients weighing >120 kg) Refills: 0	❑ AGHDiagnose Kit Select if you would like a complimentary kit of ancillary supplies for Macrilen™ preparation to accompany this prescription.	Previous GH stimulation test(s): ❑ Insulin tolerance test (ITT) ❑ Glucagon stimulation test (GST) Please include test results if available.

Please include patient's most recent clinical notes and/or labs.

Allergies: ❑ No known allergies

Concurrent medications:

I authorize CareConnection to forward the above prescription information to the most cost-effective Specialty Pharmacy, as dictated by the patient's insurance, in order to dispense Macrilen™ to the above-named patient. If there are multiple options at the same cost to the patient, I understand that CareConnection will contact me to select which pharmacy to contact. I understand that state law may require the pharmacy to contact me directly. The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

Prescriber's signature: ______________________ Date: ________
Dispense as written (no signature stamps)

Prescriber's signature: ______________________ Date: ________
Substitution permitted (no signature stamps)

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Patient authorization for CareConnection Patient Assistance Program

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Please fax form to 1-844-622-7771

Patient authorization and signature

I, the patient, understand that CareConnection, acting on behalf of Novo Nordisk Inc. (collectively, CareConnection), must use, share, and store my protected health information (PHI) in order to provide CareConnection support. I hereby authorize CareConnection to contact my health care provider, pharmacy, insurance company, or other third-party payers, and for such parties to give CareConnection all necessary medical records and payer information, including my growth chart, medical history, clinical notes, test results, prescription drug information, and insurance information. I understand that a copy of this authorization will be provided to anyone disclosing information to CareConnection so that it may be kept with my records. This authorization expires once I have notified CareConnection that I have completed my growth hormone treatment (unless a shorter time period is required by state law), or unless I notify both my health care provider and CareConnection (at fax number **1-844-622-7771**) in writing that I withdraw my approval to share my health information. My withdrawal of approval will not affect any disclosure of PHI made prior to my withdrawal.

I understand that once my health information is released to CareConnection, it may no longer be protected by state and federal law but that CareConnection will protect such information and use it only for the purposes stated above. I understand that CareConnection may share my PHI with other parties in order to administer the program. I understand that I have a right to receive a copy of this authorization.

I understand that I do not have to sign the authorization form. If I choose not to sign it, my ability to obtain treatment and my eligibility for benefits under my health plan will not be affected. However, if I do not sign the authorization form, CareConnection may not be able to provide reimbursement help or find out if I am eligible for any other CareConnection support.

Print patient's name ______________________ **Print legal representative's name** ______________________

Signature of patient ______________________ **OR** **Signature of legal representative (parent or guardian)** ______________________ **Date** __________

I agree that the information I am providing may be used by Novo Nordisk, its affiliates, or vendors to keep me informed about new products, services, special offers, or other opportunities that may be of interest to me, as they become available. THESE COMMUNICATIONS MAY CONTAIN MATERIAL MARKETING OR ADVERTISING NOVO NORDISK PRODUCTS, GOODS, OR SERVICES. Novo Nordisk will take appropriate measures to protect my information. I can stop Novo Nordisk from sending me future communications by calling **1-877-744-2579**, sending a brief note with my name and address to Novo Nordisk at 800 Scudders Mill Road, Plainsboro, NJ 08536, or by clicking on the "unsubscribe" link in future email communications. By providing my information to Novo Nordisk and acknowledging below, I certify that I am at least eighteen (18) years of age.

Print patient's name ______________________ **Print legal representative's name** ______________________

Signature of patient ______________________ **OR** **Signature of legal representative (parent or guardian)** ______________________ **Date** __________

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