STATEMENT OF MEDICAL NECESSITY

AXIS™ CENTER

Phone: 1-877-714-AXIS (2947)
Fax: 866-823-9554

ICD10: E88.1

EGRIFTA®
tesamorelin for injection

Information to be Completed by Physician

Physician _____

Office/Clinic/Institution _____

Street Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Tax ID# _____

Medicaid # _____ NPI # _____

Office Contact:

Name _____ Phone _____

Diagnosis:

Excess abdominal fat in HIV patients with Lipodystrophy ☐YES ☐NO

Medical History:

The patient is currently receiving antiretroviral therapy (ART) ☐YES ☐NO

Please provide the patient's:

Blood fasting glucose: _____ mg/dL

BMI: _____ kg/m^2

Waist Circumference: _____ cm

Hip Circumference: _____ cm

Waist-to-hip Ratio: _____

Injection Training to be completed by EMD Serono:

☐YES ☐NO

Training Location:

☐ MD Office ☐ Home
☐ Other (please specify location): _____

Requested Pharmacy:

☐ Accredo
☐ Aetna Specialty
☐ CIGNA Home Delivery Pharmacy
☐ Curascript
☐ CVS/Caremark
☐ Humana RightSource
☐ ICORE
☐ Prescription Solutions
☐ Walgreens Specialty
☑ Other: AcariaHealth

Important: Pharmacy choice will be honored unless otherwise mandated by the patient's insurance provider.

Rev.: 10.01.2015

Patient Information

Patient Name _____

DOB _____ ☐ Male ☐ Female

Street Address _____

City _____ State Zip _____

Daytime # _____ Evening # _____

Cell Phone # _____ Email _____

☐ OKAY TO CALL: ☐ Daytime ☐ Evening ☐ Cell

☐ OKAY TO LEAVE DETAILED MESSAGE: ☐ Daytime ☐ Evening ☐ Cell

☐ COPY OF FRONT AND BACK OF INSURANCE CARD ENCLOSED

Insurance Information

Primary Insurance _____

Insurance ID: _____

Important: Attach a copy, front and back, of patient's insurance card

Rx and Statement of Medical Necessity to be Completed and Signed by Physician

Prescription: ☐ *EGRIFTA*® (tesamorelin for injection) with injection kit

Ship to: ☐ Home ☐ Physician's Office ☐ Pharmacy

Quantity: 30 *EGRIFTA*® 2 mg powder vials and 30 10-mL bottles of Sterile water

Dosage and Directions for Use: 2 mg subcutaneous injection daily

Number of Refills: _____ **Additional Instructions:**

_____

_____

Physician Certification:

I certify that the prescribed therapy is medically necessary, that the information in this Statement of Medical Necessity is accurate to the best of my knowledge, and that I am aware of the risks and benefits associated with use of *EGRIFTA*®. I authorize EMD Serono (1) to provide any information on this form to the insurer of the named patient and (2) forward the above prescription, by fax or by other mode of delivery, to the chosen pharmacy.

Physician's Name _____ Date _____

X _____
(Physician's Signature)

PATIENT AUTHORIZATION

AXIS™ CENTER

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Fax: 866-823-9554

EGRIFTA®
tesamorelin for injection

Information to be Completed by Patient

Patient's Name_____

Address_____

Home Phone #_____

DOB_____/_____/_____

Authorization to Use and Disclose Health and Other Personal Information

I authorize my physician and their staff to disclose my health and other personal information, including, but not limited to, the information on my completed Statement of Medical Necessity form, and any confidential HIV-related information if applicable, including HIV test results, to EMD Serono, Inc. and its agents and representatives (collectively "EMD Serono") so that EMD Serono may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans and other third-party payers (collectively, "Third Parties") in order to:

(1) facilitate the filling of my prescription for and the delivery and administration of *EGRIFTA*®;

(2) assist me in obtaining insurance coverage for *EGRIFTA*®;

(3) contact me by mail, e-mail, text, and/or telephone to enroll me in, and administer, programs that provide *EGRIFTA*® support services;

(4) provide me with free educational information and materials;

(5) conduct surveys to measure my satisfaction with *EGRIFTA*® and *EGRIFTA*® support services; and

(6) for such other purposes as may be required or permitted by applicable law.

I further authorize the Third Parties to disclose health and other personal information about me in their possession to EMD Serono in order to assist EMD Serono in accomplishing the purposes described above.

I understand that once my information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy laws (the Health Insurance Portability and Accountability Act). However, I understand that EMD Serono will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative's) separate written consent.

I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive *EGRIFTA*®, but it will limit my ability to receive support services for *EGRIFTA*®.

I understand that this authorization will remain in effect for ten years from the date of my signature, unless I revoke it earlier by contacting EMD Serono in writing at One Technology Place, Rockland, MA 02370.

If I revoke this authorization, EMD Serono will stop using and disclosing my information as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization.

I understand that the services provided by EMD Serono that are described in this authorization can be changed at any time, without prior notification.

I understand that certain Third Parties may receive compensation in exchange for their disclosure of my information to EMD Serono.

I also understand that I have the right to receive a copy of this authorization.

_____ _____

Patient name (please print) Date

_____

Patient signature