Patient AXIS Center® and SEROSTIM® Start Form

Patient and Prescriber must sign this form. Ensure all sections are complete.
An incomplete Start Form may delay the start of treatment.

PATIENT AXIS CENTER®

Serostim® (somatropin) for injection 4 mg 5 mg 6 mg

Fax both pages of form to: 1-866-823-9554

Questions? 1-877-714-AXIS (2947)

Enroll Online Serostim.com

Email PatientAxisCenter@emdserono.com

Services Requested: ☐ Benefits Verification ☐ Financial Assistance ☐ Nursing Support

1 Patient Information

Patient First Name _____ Patient Last Name _____

Date of Birth (mm/dd/yyyy) _____ Gender: ☐ Male ☐ Female

Home Address _____

City _____ State _____ Zip _____

Patient Phone _____ ☐ Home ☐ Cell

Okay to leave detailed message? ☐ Yes ☐ No

Email (required for Patient AXIS Center support communications) _____

Preferred Method of Communication:
☐ Home Phone ☐ Email ☐ Text (opt-in below)
☐ Cell Phone (if not provided above): _____

2 Patient (or Personal Representative) Authorization

2A I have read and understand the Authorization to Use and Disclose Health and Other Personal Information and agree to the terms on pages 3-4.

SIGN HERE

Patient (or Personal Representative) Signature _____

Date Signed _____

Personal Representative Full Name (if applicable) _____

Personal Representative Authority/Relationship (if applicable):
☐ Legal Guardian ☐ Power of Attorney

2B **FOR CALIFORNIA PATIENTS ONLY**

☐ By checking this box, I request that my Authorization to Use and Disclose Health and Other Personal Information and Marketing Consent (if selected below) remain valid for 10 years from the date of signature. If not, such consent will expire one (1) year from the date of signature.

2C **Marketing Consent (optional)**

☐ By checking this box, I authorize EMD Serono and its affiliates to use my Health Information for marketing and market research purposes, including, but not limited to, providing educational and promotional materials, information, offers, and services related to my therapy or medical condition, and contacting me to participate in focus groups, surveys, or interviews funded or sent by EMD Serono, Patient AXIS Center, or EMD Serono affiliates. I understand I may withdraw my consent as described in this form.

2D **Opt-In for Automated Text Messages (optional)**

☐ By checking this box, I consent to receive text messages from EMD Serono and agree to the terms outlined on page 4.

3 Patient Insurance Information (please include a copy of both sides of insurance card)

☐ Check here if patient does not have insurance.

Primary Insurance Carrier _____

Cardholder Name (if different than patient) _____

Member ID # _____ Group # _____ Insurance Phone _____

Insurance Type: ☐ Employer ☐ Medicaid ☐ Medicare ☐ Healthcare Exchange ☐ Other: _____

Prescription Insurance Carrier _____

Rx Member ID # _____ Rx Group # _____ Rx Insurance Phone _____

Rx PCN # _____ Rx BIN # _____

Has prior authorization (PA) been intiated? ☐ Yes ☐ No

If yes, PA status? ☐ Approved ☐ Denied ☐ In Progress

4 Prescriber Information

Prescriber First Name _____ Prescriber Last Name _____

Prescriber Address _____

City _____ State _____ Zip _____

NPI # _____ Tax ID # _____

Office / Clinic / Institution Name _____

Office Contact Name _____

Office Contact Email _____

Office Contact Phone _____ (_____) Extension _____ Office Fax _____

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5 Patient Allergies and Medications

Patient First Name _____ Patient Last Name _____

Date of Birth (mm/dd/yyyy) _____

Allergies: ☐ No known drug allergies (NKDA)
☐ Yes (specify): _____

Current Medications: (list all)

6 Prescription for SEROSTIM® (somatropin) for Injection

Preferred Pharmacy Name _____

Pharmacy Phone _____

Has a prescription already been sent? ☐ Yes ☐ No

6A Diagnosis Information

Does the patient have a diagnosis of HIV-associated wasting?
☐ Yes ☐ No

Diagnosis Code (ICD-10) select all that apply:

- ☐ **R64** Cachexia
- ☐ **B20** Human Immunodeficiency Virus (HIV)
- ☐ **E88.A** Wasting disease (syndrome) due to underlying condition

6B SEROSTIM Dosages

Patient's Current Weight _____ Date Recorded _____

Prescribed Dose:

_____ mg per day for 28 days Refills: _____

SEROSTIM Weight-based Dosage Recommendations ***(for reference only)***

>121 lb	>55 kg	6 mg SC daily, 7 vial pack*
99-121 lb	45-55 kg	5 mg SC daily, 7 vial pack*
75-99 lb	35-45 kg	4 mg SC daily, 7 vial pack*
<75 lb	<35 kg	0.1 mg/kg SC daily*

*Based on an approximate daily dosage of 0.1mg/KG

6C Reconstitution and Administration

Both injection (administration) and reconstitution (mixing) selections are required.

Injection (½" needle, 3-cc syringe)
Check one: ☐ 29G ☐ 30G

Reconstitution (1" needle, 20 G size)
Check one: ☐ 0.5ml ☐ 1.0ml

Directions for use: To be used for SEROSTIM administration

Quantity to dispense: _____ Refills: _____

6D Virtual Injection Training

Injection training for patient from a Patient AXIS Center Nurse?
☐ Yes ☐ No

7 Prescriber Authorization

I certify that therapy with SEROSTIM is medically necessary for the patient identified in Section 1 of this Start Form ("Patient").

I have reviewed the current SEROSTIM Prescribing Information and will be supervising Patient's treatment. I have received from Patient, or their personal representative, the necessary authorization to release, in accordance with applicable federal and state law regulations, referenced medical and/or other patient information relating to SEROSTIM therapy to EMD Serono, Inc., including its affiliates, representatives, and agents (collectively "EMD Serono"), for the purpose of seeking information related to coverage and/or assisting in initiating or continuing SEROSTIM therapy. I agree that product provided shall only be used for Patient. I understand that I am under no obligation to prescribe or purchase SEROSTIM or any other product manufactured by EMD Serono, and I certify I have received nothing of value from EMD Serono or its agents or representatives for prescribing an EMD Serono product.

I authorize the Patient AXIS Center, on behalf of EMD Serono, as my designated agent to forward/transmit this prescription under applicable law to a pharmacy within the SEROSTIM specialty pharmacy network.

SIGN HERE

Dispense As Written: _____
Prescriber Signature

OR

Substitution Permitted: _____
Prescriber Signature

_____
Prescriber Printed Name

_____
Date Signed

Patient Authorization & Consent Information

Authorization to Use and Disclose Personal Information

By signing the Patient AXIS Center® and SEROSTIM® Start Form, I agree to the following:

- I authorize my treating physician(s), pharmacy(ies), health insurance company(ies), prescription drug plan(s), and other parties providing me health care or paying for my health care (collectively, "My Health Care Providers and Plans") to disclose my personal and protected health information ("Health Information") to EMD Serono, Inc. and its agents and representatives (collectively "EMD Serono"). My Health Information may include, but is not limited to, information regarding my diagnosis of and treatment for HIV-associated wasting, information included in the SEROSTIM Start Form, and any other information deemed relevant by My Health Care Providers and Plans that may be considered sensitive or specially protected by law. EMD Serono may use and further disclose my Health Information to My Health Care Providers and Plans or other third parties in order to: (1) enroll me in and administer the Patient AXIS Center Program and contact me by mail, email, or by live call at the telephone number(s) listed above, or to any future telephone number(s) provided by me; (2) conduct a benefits investigation and coordinate my insurance coverage for any prescribed EMD Serono product(s); (3) facilitate the filling of my prescription for and the delivery and administration of that product(s); and (4) contact me regarding the Patient AXIS Center Program and conduct quality assurance, surveys, and other internal business activities or analyses in connection with the Patient AXIS Center Program.
- I understand that once my Health Information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy laws (e.g., the Health Insurance Portability and Accountability Act (HIPAA)) and may be further disclosed to others.
- For more information on your privacy rights and choices, please see EMD Serono's privacy notice at https://www.emdserono.com/us-en/privacy-policy.html.
- I understand that I may refuse to sign this authorization and such refusal will not affect my eligibility to receive any EMD Serono product, my treatment, payment for treatment, or eligibility for or enrollment in health benefits, but it will limit my ability to receive Patient AXIS Center Program services. I understand and agree that this authorization will remain in effect for 10 years from the date of my signature (unless I am a California resident, in which case this authorization will remain in effect for 1 year, or for 10 years if I check the box in Section 2B above) unless I revoke it earlier by contacting EMD Serono at 1-877-714-2947. If I revoke this authorization, My Health Care Providers and Plans will stop disclosing my Health Information to EMD Serono, and EMD Serono will stop using and disclosing this information, as soon as possible, but the revocation will not affect prior use or disclosure of my Health Information in reliance on this authorization.
- I also understand that I have the right to receive a signed copy of this authorization.

To provide consent, please complete and sign section 2 under Patient Authorization on page 1.

Patient Authorization & Consent Information, cont'd

Patient Consent for the Patient AXIS Center® Program, Terms, Conditions ("Consent")

The Patient AXIS Center ("Program") is a patient support program for eligible patients who have been prescribed SEROSTIM® (somatropin) for injection by their physician. By signing the Patient AXIS Center and SEROSTIM Start Form, I agree and certify the following:

- I confirm that all insurance information is complete and accurate. Additionally, during participation in the Patient AXIS Center, and while I am receiving treatment with SEROSTIM, I agree to immediately notify the Patient AXIS Center if my health insurance status changes, if I obtain any new health insurance plan, or if I become entitled to, or enroll in a government health insurance program (i.e., Medicare or Medicaid).
- I understand that EMD Serono reserves the rights to modify, change, or terminate the Patient AXIS Center or any services at any time without any notice.
- I understand that if I am a California resident I have certain rights with respect to my personal information that are described in the EMD Serono California Consumer Privacy Act Privacy Policy available at https://www.emdserono.com/us-en/privacy-policy.html.
- I understand that patients who receive drug benefits for Medicaid, Medicare, or other federal or state programs may not be eligible for financial support services. Other Program restrictions may apply.
- I understand that EMD Serono, through the Patient AXIS Center, may collect relevant financial (e.g., income) and other Personal Information for the purposes of determining my eligibility for the Program, subsequently administering the Program benefits or related services, and as further described in the Program Authorization.
- By signing on page 1, I am electing to enroll in the Patient AXIS Center and direct all disclosures of my Information in connection with such services (which may include, but are not limited to, verification of insurance benefits and drug coverage, prior authorization support, financial assistance with co-pays, patient assistance programs, disease state/product education, other related programs, communication with me or my prescribing physician by mail, email, or telephone about my medical condition, treatment, care management, product information, and health insurance).

To provide consent, please complete and sign section 2 under Patient Authorization on page 1.

Opt-In for Automated Text Messages

I authorize EMD Serono, Inc. (or its agents), to send text messages to the cell phone number I have provided on page 1 of this form (or to any future cell phone number(s) provided by me to EMD Serono, using an automatic telephone dialing system on a recurring basis regarding EMD Serono's programs or products. This opt-in also enables EMD Serono to contact me by text message to provide me with Program services, if applicable. Agreeing to this opt-in is not a condition of participating in the Program or purchasing products, goods, or services from EMD Serono. I understand that my cell phone service provider may charge me fees for texts sent to me and I agree that EMD Serono will have no liability for the cost of any such calls or texts. EMD Serono's Legal Statement and Privacy Policy apply. At any time, I may opt-out or withdraw my consent to receive text messages by replying "STOP" via return text message or contacting EMD Serono in writing at: EMD Serono, Patient AXIS Center, 200 Pier 4 Blvd., Boston, MA 02210.

To opt in, please check the box in section 2D under Patient Authorization on page 1.