Patient AXIS Center® and Serostim® Start Form

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

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

Fax to 866-823-9554

Enroll Online CoverMyMeds.com

PATIENT AXIS CENTER®

Patient and Prescriber signatures are required on this form.

1 | Patient Information

First Name | Last Name

Date of Birth (MM/DD/YYY) | Gender (optional)

Home Address

City | State | Zip

Preferred Contact Number ☐ Home ☐ Work ☐ Cell

Okay to Leave Detailed Message at Preferred number? ☐ Yes ☐ No

Email (Important: used by Patient AXIS Center® for patient support)

Preferred Method of Communication

☐ Phone ☐ Email ☐ Text (opt-in below)

Cell if not provided above

2 | Patient Authorization *(To be completed by patient or legal representative)*

2A | I have read, understand and agree to the release of my protected health information, as described on page 2 of this form:

SIGNATURE

Patient or legal representative | **Date**

Legal representative name *(if applicable)*

Authority/relationship of legal representative *(if applicable):*

☐ Legal Guardian

☐ Power of Attorney

2B | ☐ By checking this box, I confirm that I have read and understand the Opt-in for Marketing text messages and agree to the terms on page 2.

3 | Patient Insurance Information *(Please include a copy of both sides of the insurance card)*

Primary Insurance

Cardholder Name (if different than patient)

ID # | Group # | Phone #

Check here if patient does not have insurance ☐

Prescription Insurance Carrier

Rx ID # | Rx Group # | Rx BIN #

Rx PCN | Phone #

4 | Prescriber Information

Prescriber First Name | Prescriber Last Name

Address

City | State | Zip

Tax ID # | NPI #

Office/Clinic/Institution Name

Office Contact Name

Office Contact Phone | Office Fax

Office Contact Email

5 | Prescription Information

5A | Diagnosis Information

Does the patient have a diagnosis of HIV-associated Wasting?

☐ Yes ☐ No

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

☐ **R64** Cachexia

☐ **B20** Human Immunodeficiency Virus[HIV]

☐ **B22.2** Human Immunodeficiency Virus [HIV] disease resulting in other specified diseases

5B | Serostim® Dosages

Patient's Current Weight | Date Recorded

☐ 4 mg, multi dose 7 vial pack

☐ 5 mg 7 vial pack

☐ 6 mg 7 vial pack

Prescribed Dose

_____ mg per day for 28 days

_____ refills

5C | Reconstitution and Administration

☐ 29G, ½" needles, 3-cc syringe, with 20G, 1" needles for reconstitution

☐ 30G, ½" needles, 3-cc syringe, with 20G, 1" needles for reconstitution

Reconstitution volume

☐ 0.5ml

☐ 1.0ml

5D | Injection Training

Would you like your patient to receive injection training to be conducted by a Patient AXIS Center® Nurse?

☐ Yes ☐ No

PRESCRIBER AUTHORIZATION

By signing this form, I certify that therapy with Serostim® is medically necessary for the patient identified in this application ("Patient"). I have reviewed the current Serostim® Prescribing Information and will be supervising Patient's treatment. I have received from Patient, or his/her 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 agents or contractors (the "Company"), for the purpose of seeking information related to coverage and/or assisting in initiating or continuing Serostim® therapy. I authorize Patient AXIS Center® to transmit this prescription to a pharmacy within the Serostim® specialty pharmacy network. 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 the Company, and I certify I have received nothing of value from the Company or its agents or representatives for prescribing a Company product.

SIGNATURE

Prescriber Signature | **Date** (MM/DD/YYYY)

☐ **No Substitutions / Dispense as Written**

An incomplete Start Form may delay the start of treatment.

Complete form and fax to the Patient AXIS Center® at 866-823-9554

Authorization for Use and Disclosure of Health and Other Personal Information

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

- I authorize my physician(s), pharmacist(s), other health care providers, patient advocacy organizations and insurance companies ("My Health Care Providers and Plans") to disclose my health and other personal information, including, but not limited to, the information on this form ("My Health Information") to EMD Serono, Inc., and its agents and representatives, including any company that assists EMD Serono's Patient AXIS Center program (collectively, "EMD Serono") in order that I may participate in EMD Serono's Patient AXIS Center. My Health Information may also include, but is not limited to, information regarding my diagnosis of and treatment for the one or more conditions for which I may be or have been prescribed Serostim® (somatropin) for injection (the "Product"), financial information, insurance status, information included in any Statement of Medical Necessity for me for a Product Prescription and Service Request Form, and any other information deemed relevant by My Health Care Providers and Plans regarding my health care condition or medications.
- EMD Serono may use and further disclose my Health Information obtained pursuant to this Authorization in order to: (1) contact me by mail, email, and/or telephone to enroll me in and administer EMD Serono's Patient AXIS Center; (2) provide me with materials relating to the Patient AXIS Center; (3) verify the accuracy of the information I provide and in my application for the Patient AXIS Center; (4) provide me with reimbursement support services; and (5) conducting quality assurance, surveys, and other internal business activities in connection with the Patient AXIS Center.
- I understand that this Authorization will remain in effect for ten (10) years, or such shorter period as may be required by state law, from the date of my signature, unless I revoke this authorization earlier by contacting EMD Serono in writing at EMD Serono, Patient AXIS Center program, One Technology Place, Rockland, MA 02370. If I revoke this Authorization, My Health Care Providers and Plans will stop disclosing this information to EMD Serono.
- I understand that my refusal to sign this Authorization will not affect my ability to receive Serostim, my treatment, payment for treatment, eligibility for or enrollment in health benefits; however, such refusal will limit my ability to receive support services for Serostim through the Patient AXIS Center.
- I understand that, once my Health Information is disclosed pursuant to this Authorization, it may be subject to redisclosure and no longer protected by federal privacy laws.
- I understand that I have the right to receive a copy of this Authorization.

Patient Consent for the Patient AXIS Center®

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® (somatropin) for injection, I agree to immediately notify the Patient AXIS Center if my health insurance status changes in the future, if I obtain any new health insurance plan, or if I become entitled to, or enroll in a government health insurance program/payer (i.e., Medicare or Medicaid).
- I understand that the Patient AXIS Center reserves the right to modify, change, or terminate the Patient AXIS Center program at any time with or without 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/privacypolicy.html.
- I understand that information from Patient AXIS Center program participants may be summarized for statistical or other purposes but such summaries will not contain information that identifies me personally.
- I understand that EMD Serono, through the Patient AXIS Center, is collecting patients' relevant financial income and personal health information, including information relating to medical conditions, treatment, care management, prescriptions, and health insurance, for the purpose of determining the patients' eligibility for the Patient AXIS Center and subsequently administering the program benefits or related services.

To authorize your consent, please complete 2A: Patient Authorization on page 1, including signature line.

Opt-In for Automated Marketing Text Messages

I authorize EMD Serono, Inc. (or its agents), to send marketing text messages to the cell phone number(s) listed (or to any future telephone number(s) provided by me to EMD Serono, Inc. or its agents) using an automatic telephone dialing system on a recurring basis. This consent also enables EMD Serono to contact me by text message to provide me with Patient AXIS Center Support Program services. Signing this consent is not a condition of participating in the Patient AXIS Center Support Program or purchasing products, goods, or services from EMD Serono. I understand that my mobile 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. At any time, I may 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, One Technology Place, Rockland, MA 02370.

To authorize your consent, please check the box listed in 2B: Patient Authorization on page 1.