

**PATIENT ENROLLMENT FORM—ADULT**

**Please select your patient's growth hormone (GH) treatment experience\*:**

New to GH therapy     Continuing on SKYTROFA (lonapegsomatropin-tcqd)     Switching from previous therapy: \_\_\_\_\_

SKYTROFA FastStart     Ascendis Patient Assistance Program     Reimbursement support     SKYTROFA Auto-Injector only†  
 SKYTROFA Co-Pay Program enrollment

1-PATIENT INFORMATION/AUTHORIZATION	Patient name*: _____	Address*: _____	Other contact: _____
	Date of birth*: __/__/____ Sex*: <input type="checkbox"/> M <input type="checkbox"/> F	City*: _____	Name: _____
	Primary language: _____	State*: _____ ZIP*: _____	Relationship to patient: _____
		Phone: (____) ____-____	Phone: (____) ____-____
		Email: _____	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\*:** \_\_\_\_\_    Prior authorization (PA) submitted:     Yes     No  
**Pharmacy/Rx insurance:** \_\_\_\_\_    PA approval:     Yes     No  
 Member ID #: \_\_\_\_\_    Group ID #: \_\_\_\_\_    Date of PA approval: \_\_/\_\_/\_\_\_\_  
 Member name: \_\_\_\_\_    Reference number: \_\_\_\_\_  
 Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

**Adult GHD\*:**     Childhood onset     Adult onset

**Please check the applicable ICD-10 diagnosis code\*:**

E23.0 Hypopituitarism     E89.3 Postprocedural hypopituitarism  
 E23.1 Drug-induced hypopituitarism     Other ICD-10 code: \_\_\_\_\_

4-MEDICAL ASSESSMENT	Current weight*: _____ kg	Date of IGF-1 test: __/__/____	MRI (pituitary gland) completed:
	Date Stim Test 1: __/__/____    Date Stim Test 2: __/__/____	Results: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Agent : _____    Agent : _____	IGF-1 SDS: _____	<input type="checkbox"/> Not applicable
	Peak level: _____ ng/mL    Peak level: _____ ng/mL		Date of MRI: __/__/____

**SKYTROFA cartridge strengths for use with SKYTROFA Auto-Injector (please select one)\*:**

**0.7 mg:** (NDC 73362-012-01)     **2.1 mg:** (NDC 73362-015-01)     **3.6 mg:** (NDC 73362-004-01)     **6.3 mg:** (NDC 73362-007-01)  
 **1.4 mg:** (NDC 73362-013-01)     **2.5 mg:** (NDC 73362-016-01)     **4.3 mg:** (NDC 73362-005-01)  
 **1.8 mg:** (NDC 73362-014-01)     **3 mg:** (NDC 73362-003-01)     **5.2 mg:** (NDC 73362-006-01)

**Month(s) supply:** \_\_\_\_\_    **Refills:** \_\_\_\_\_    The SKYTROFA Auto-Injector is packaged in a separate carton.

**PREFERRED PHARMACY**

Preferred pharmacy: \_\_\_\_\_    Pharmacy phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_    Pharmacy fax: (\_\_\_\_) \_\_\_\_-\_\_\_\_

6-PRESCRIBER INFORMATION	Prescriber name*: _____	Practice*: _____	Office contact*: _____
	Prescriber NPI #*: _____	Address*: _____	Office contact phone*: (____) ____-____
	DEA #: _____	City*: _____	Office contact fax*: (____) ____-____
		State*: _____    ZIP*: _____	Office contact email*: _____

By signing below, I certify that: (a) I am a licensed practitioner, in good standing under applicable state law; (b) the information I have provided on this enrollment form is, to the best of my knowledge, true, complete, and accurate; and (c) I have obtained the necessary authorization from the patient, patient's caregiver, and/or legal representative to use, disclose, share, or otherwise release the above information, including the patient's protected health information ("PHI") for the purpose of providing patient assistance, including verifying insurance coverage, arranging training services, and evaluating patient's eligibility for alternate sources of funding. Further, I appoint the Ascendis Signature Access Program® ("A-S-A-P"), on my behalf, to convey this prescription to the dispensing pharmacy. I will immediately notify Ascendis Pharma if the above-named patient, individually or through their caregiver, and/or legal representative, revokes their consent. I give you permission to contact me, or the above-named patient, patient's caregiver, and/or legal representative.

Dispense as written     Substitution allowed  
 Prescriber signature †: \_\_\_\_\_    Prescriber signature †: \_\_\_\_\_  
 Date: \_\_/\_\_/\_\_\_\_    Date: \_\_/\_\_/\_\_\_\_

**8-TRAINING AUTHORIZATION**

**Nurse Injection Training Authorization** A-S-A-P will provide my patient 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.