

**PATIENT ENROLLMENT FORM—PEDIATRIC**

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

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

SKYTROFA FastStart     Reimbursement support     SKYTROFA Auto-Injector only†

1-PATIENT INFORMATION/AUTHORIZATION	Patient name*: _____	Parent/Guardian #1:	Parent/Guardian #2:
	Date of birth*: __/__/____ Sex*: <input type="checkbox"/> M <input type="checkbox"/> F	Name*: _____	Name: _____
	Address*: _____	Relationship to patient*: _____	Relationship to patient: _____
	City*: _____ State*: ____ ZIP*: _____	Phone*: (____) ____-____	Phone: (____) ____-____
	Primary language: _____	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

<p><b>Primary medical insurance*:</b> _____</p> <p><b>Pharmacy/Rx insurance:</b> _____</p> <p>Member ID #*: _____ Group ID #: _____</p> <p>Member name: _____</p> <p>Phone: (____) ____-____</p>	<p>Prior authorization (PA) submitted:    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>PA approval:    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Date of PA approval: __/__/____</p> <p>Reference number: _____</p>
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**Please check the applicable ICD-10 diagnosis code. Pediatric GH deficiency (GHD)\*:**

E23.0 Isolated GH deficiency     E23.0 Idiopathic GH deficiency     E23.1 Drug-induced hypopituitarism  
 E23.0 Hypopituitarism     E89.3 Postprocedural hypopituitarism  
 E23.0 Panhypopituitarism     Other ICD-10 code: \_\_\_\_\_

4-MEDICAL ASSESSMENT	<p><b>Current weight*:</b> _____ kg</p> <p>Weight SDS: _____</p> <p>Current height: _____ cm</p> <p>Height SDS: _____</p> <p>Growth velocity: _____ cm/yr</p>	<p>Date of GH stimulation test: __/__/____</p> <p>Agent 1: _____ Peak level: _____ ng/mL</p> <p>Agent 2: _____ Peak level: _____ ng/mL</p> <p>Date of bone age X-ray: __/__/____</p> <p>Bone age: _____ Chronological age: _____</p>	<p>Date of IGF-1 test: __/__/____</p> <p>Results: _____</p> <p>IGF-1 SDS: _____</p> <p>MRI (pituitary gland) completed:  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Not applicable</p>
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**SKYTROFA cartridge strengths for use with SKYTROFA Auto-Injector (please select one)\*:**

**Inject 1 cartridge subcutaneously per weekly dose of:**

**3 mg:** (NDC 73362-003-01) **11.5–13.9 kg**  
 **3.6 mg:** (NDC 73362-004-01) **14.0–16.4 kg**  
 **4.3 mg:** (NDC 73362-005-01) **16.5–19.9 kg**  
 **5.2 mg:** (NDC 73362-006-01) **20.0–23.9 kg**  
 **6.3 mg:** (NDC 73362-007-01) **24.0–28.9 kg**  
 \_\_\_\_\_

**7.6 mg:** (NDC 73362-008-01) **29.0–34.9 kg**  
 **9.1 mg:** (NDC 73362-009-01) **35.0–41.9 kg**  
 **11 mg:** (NDC 73362-010-01) **42.0–50.9 kg**  
 **13.3 mg:** (NDC 73362-011-01) **51.0–60.4 kg**  
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**Inject 2 cartridges subcutaneously per weekly dose of (for patients ≥ 60.5 kg):**

**7.6 mg:** (NDC 73362-008-01) **60.5–69.9 kg**  
 **9.1 mg:** (NDC 73362-009-01) **70.0–84.9 kg**  
 **11 mg:** (NDC 73362-010-01) **85.0–100.0 kg**  
 \_\_\_\_\_

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

5-PRESCRIPTION/DOSEAGE	<input type="checkbox"/> CVS <input type="checkbox"/> Optum <input type="checkbox"/> Lumicera <input type="checkbox"/> Accredo <input type="checkbox"/> Walgreens Specialty Pharmacy <input type="checkbox"/> Other: _____
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6-PRESCRIBER INFORMATION	Prescriber name*: _____	Prescriber NPI #: _____	Office contact*: _____
	Practice*: _____	Address*: _____	Office contact phone*: (____) ____-____
	DEA #: _____	City*: _____ State*: _____	Office contact fax*: (____) ____-____
	Prescriber Tax ID #: _____	ZIP*: _____	Office contact email*: _____

I certify that the information provided above is, to the best of my knowledge current, complete, and accurate and the therapy I have prescribed above is medically necessary for this patient and patient's records contain supporting documentation that substantiates the utilization and medical necessity of the therapy. I have discussed A-S-A-P with my patient and my patient would like to be screened for eligibility for A-S-A-P and provided, if applicable, any services under A-S-A-P. I will comply with my own state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language. I understand that noncompliance with state-specific requirements could result in outreach to the prescriber. I authorize the provision to patient of ancillary supplies, such as sharps containers and alcohol swabs, to administer the therapy. I acknowledge that the prescription may only be filled by a limited number of specialty pharmacies and prescriber authorizes Ascendis and those acting on its behalf to transmit the prescription electronically, by facsimile, or by mail to the appropriate dispensing specialty pharmacy.

7-PRESCRIBER AUTHORIZATION	<input type="checkbox"/> Dispense as written Prescriber signature*: _____ Date: __/__/____	<input type="checkbox"/> Substitution allowed Prescriber signature*: _____ Date: __/__/____
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**8-TRAINING AUTHORIZATION** Nurse Injection Training Authorization A-S-A-P will provide my patient and/or his/her caregiver 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.