A·S·A·P
ASCENDIS SIGNATURE ACCESS PROGRAM®

Fax: 1-888-436-0193
Phone: 1-844-44ASCENDIS (1-844-442-7236)
Email to: info@ascendissupport.com
www.Skytrofa.com

Skytrofa®
lonapegsomatropin-tcgd

*Required field.

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*: _____
Date of birth*: __ __ ____ Sex*: ☐ M ☐ F
Address*: _____
City*: _____ State*: ___ ZIP*: _____
Primary language: _____

Parent/Guardian #1:
Name*: _____
Relationship to patient*: _____
Phone*: ___ ___ ____
Email: _____

Parent/Guardian #2:
Name: _____
Relationship to patient: _____
Phone: ___ ___ ____
Email: _____

2-INSURANCE

☐ 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*: _____
Pharmacy/Rx insurance: _____
Member ID #*: _____ Group ID #: _____
Member name: _____
Phone: ___ ___ ____

Prior authorization (PA) submitted: ☐ Yes ☐ No
PA approval: ☐ Yes ☐ No
Date of PA approval: __ __ ____
Reference number: _____

3-DIAGNOSIS

Please check the applicable ICD-10 diagnosis code. Pediatric GH deficiency (GHD)*:

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

4-MEDICAL ASSESSMENT

Current weight*: _____ kg
Weight SDS: _____
Current height: _____ cm
Height SDS: _____
Growth velocity: _____ cm/yr

Date of GH stimulation test: __ __ ____
Agent 1: _____ Peak level: _____ ng/mL
Agent 2: _____ Peak level: _____ ng/mL
Date of bone age X-ray: __ __ ____
Bone age: _____ Chronological age: _____

Date of IGF-1 test: __ __ ____
Results: _____
IGF-1 SDS: _____
MRI (pituitary gland) completed:
☐ Yes ☐ No ☐ Not applicable

5-PRESCRIPTION/DOSAGE

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

1 cartridge 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**

2 cartridges 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.

PREFERRED SP

☐ CVS ☐ Optum ☐ Maxor
☐ Accredo ☐ AllianceRx Walgreens Pharmacy ☐ Other: _____

6-PRESCRIBER INFORMATION

Prescriber name*: _____
Practice*: _____
DEA #: _____
Prescriber Tax ID #: _____

Prescriber NPI #*: _____
Address*: _____
City*: _____ State*: _____
ZIP*: _____

Office contact*: _____
Office contact phone*: ___ ___ ____
Office contact fax*: ___ ___ ____
Office contact email*: _____

7-PRESCRIBER AUTHORIZATION‡

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
Prescriber signature‡: _____
Date: __ __ ____

☐ Substitution allowed
Prescriber signature‡: _____
Date: __ __ ____

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.

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A·S·A·P
ASCENDIS SIGNATURE ACCESS PROGRAM®

Skytrofa®
lonapegsomatropin-tcgd

Ascendis Pharma
Patient Authorization Form

By signing below, I authorize my healthcare providers, pharmacies, and health insurance plan (collectively, my "Health Team") to share my contact and health information (personal health information, or "PHI") with Ascendis Pharma Endocrinology, Inc., its affiliates, and their respective vendors (collectively, "Ascendis") in connection with my participation in the Ascendis Signature Access Program® (A·S·A·P), as detailed below. I authorize Ascendis to communicate with my Health Team about me and use my PHI in order to: (1) assess my eligibility for the A·S·A·P, co-pay support, or free drug programs; (2) provide me with benefits verification and reimbursement support; (3) provide me with devices or starter kits where appropriate and disease management or other educational materials, and (4) help evaluate and improve Ascendis products, services, and operations. I also authorize my Health Team to give me information about Ascendis products and services, understanding that it may receive financial remuneration for doing so. I understand that once my PHI is shared pursuant to this authorization form, it may no longer be protected by applicable privacy laws and could be re-disclosed, but that Ascendis intends to use and share my PHI only for the purposes described in this form or as otherwise permitted by law. I understand that I do not have to sign this form in order to receive medical treatment or health insurance coverage. However, if I do not sign this form, A·S·A·P will not be able to provide me with any assistance.

I understand that this authorization will remain in effect for five (5) years (unless a shorter time period is required by applicable law), unless I notify both my healthcare provider and Ascendis (by fax to 1-888-436-0193 or by mail to PO Box 1587, Jeffersonville, IN 47131) that I am revoking the authorization. I understand that if I revoke this authorization, that will not invalidate any use or disclosure of my PHI that took place before my notice of revocation was received by Ascendis. I understand I am entitled to receive a copy of this form after I have signed it below.

☐ By checking this box, I also consent to receive promotional or marketing communications from Ascendis and A·S·A·P. I understand that I can opt out of these communications at any time by contacting A·S·A·P at 1-844-442-7236.

Signature of Patient or Patient Representative	Printed name of Signer	Date
Printed name of Patient	Relationship to Patient	Date

If signed by patient representative, please indicate below the authority to act on behalf of the patient:

☐ Parent ☐ Legal Guardian ☐ Power of Attorney to make healthcare decisions

☐ Other: _____

For details about how we collect and use PHI, including applicable US privacy rights and notices under applicable state law, please visit https://ascendispharma.us/privacy-policy/.

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