Patient Authorization

Please fill out form completely and **fax to 877.828.1052**

OmniSource is a comprehensive support program dedicated to assisting patients and caregivers with the Omnitrope® (somatropin [rDNA origin] for injection) treatment experience. The people at OmniSource are committed to answering your non-clinical questions, helping to guide patients through the insurance process, providing a starter kit when insurance coverage is approved, and providing training with a Nurse Trainer for the first injection if your child's doctor requests it.

Please read this entire form and sign in the spaces indicated. You or your healthcare team should fax this signed form to OmniSource at 877.828.1052.

Patient/Parent/Legal Guardian Name (print) ______________________ Relationship to Patient ____________

Address______________________________City__________State________ZIP________

Home Phone ______________________ Work or Cell Phone ______________________

Release for Prescription and Payment

I authorize my Doctor and his/her staff, my employer, my health insurer and/or specialty pharmacy to disclose my protected health information (PHI) (as noted on the Statement of Medical Necessity) to Sandoz designated agents who have been hired to administer the OmniSource Patient Support Program to use and/or disclose, as needed, to coordinate the receipt, payment, and proper administration of Omnitrope as prescribed by my Doctor. I understand that once my health information is disclosed it may no longer be protected by federal law regarding patient privacy and that neither my Doctor, my employer, nor my health insurer can guarantee that it will not be re-disclosed to a third party. I understand that I may refuse to sign this Authorization and my refusal or future revocation will not affect the commencement, continuation, or quality of my treatment by my Doctor; however, I may no longer be eligible for the OmniSource Patient Support Program. This Authorization is valid for 5 years after the date of my signature. I acknowledge that I would like to participate in the OmniSource Patient Support Program. I understand that by enrolling in the program, the program will contact me directly to follow up on my therapy.

Patient/Parent/Legal Guardian Signature ______________________________ Date__________

I authorize designated agents of Sandoz to use and disclose personal information, including health information, it receives about me to a specialty pharmacy that will fill my prescription and may invite me to participate in disease management programs. I understand and agree that my personal information may be used and disclosed by the specialty pharmacy and shared with designated agents of Sandoz for reimbursement purposes and for the administration of the OmniSource Patient Support Program. I understand that designated agents of Sandoz will not release my information to any other party without my express consent. I understand that I may refuse to sign or may revoke (at any time) this Authorization. I understand that if I revoke this Authorization, I will no longer be able to participate in the OmniSource Patient Support Program. To revoke this Authorization contact 877-456-6794. This Authorization is valid for 5 years after the date of my signature. I also understand that the OmniSource Patient Support Program may be changed or ended at any time without prior notification. I understand that I may receive a copy of this Authorization.

Patient/Parent/Legal Guardian Signature ______________________________ Date__________

Patient Support Program

Yes! In addition to the prescription and reimbursement components of the OmniSource Patient Support Program, I would also like to sign up to receive additional product information and services from Sandoz.

By signing below, I agree that the authorized agent(s) of Sandoz may use and disclose my personal information to deliver these services and may share information with my healthcare professional for the purposes of monitoring and managing my health. Sandoz or its authorized agent(s) may also contact me to solicit my opinions regarding their products and services.

Yes, I agree to receive calls from the OmniSource Patient Support Program and/or Sandoz notifying me of important changes and updates and to solicit my feedback on programs and services at the phone number indicated below. I understand that my cell phone carrier's standard rates may apply for calls or text messages to my cell phone. I may revoke my consent at any time by calling 877-456-6794.

Patient Telephone Number ______________________________

☐ Use Telephone Number on the Statement of Medical Necessity

Patient/Parent/Legal Guardian Signature ______________________________ Date__________

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