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

❑ New to growth hormone (GH) therapy ❑ Continuing on SKYTROFA ❑ Switching from previous therapy _____

❑ SKYTROFA–FastStart ❑ Reimbursement support ❑ SKYTROFA Auto-Injector only*

1-PATIENT INFORMATION/ AUTHORIZATION

Patient name: _____
Date of birth: Gender: ❑ 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 _____
Phone: (_ _ _) _ _ _ - _ _ _ _
Member name: _____
Member ID #: _____ Group ID #: _____

Pharmacy/Rx insurance _____
Patient name: _____
Phone: (_ _ _) _ _ _ - _ _ _ _ Member ID #: _____
Group ID #: _____ Rx BIN #: _____ Rx PCN #: _____

3-CODE

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: _____

MEDICAL ASSESSMENT

Date of MRI (pituitary gland):
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: _____

Current height: _____ cm
Height SDS: _____
Growth velocity: _____ cm/yr
Birth mother's height: _____ cm
Birth father's height: _____ cm
Predicted adult height: _____ cm

Date of IGF-1 test:
Results: _____
IGF-1 SDS: _____
Current weight: _____ kg
Weight SDS: _____

5-PRESCRIPTION/ DOSAGE

Recommended weight-based dosing ranges below are based on 0.24 mg/kg/week.
Patient's current weight: _____ **kg** Total per weekly dose: _____ mg SKYTROFA

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: 1 **Refills:** 11 The SKYTROFA Auto-Injector is packaged in a separate carton.

PREFERRED SP

❑ CVS ❑ Optum ❑ Other: _____
❑ Accredo ❑ AllianceRx Walgreens Pharmacy

6-PRESCRIBER INFORMATION

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

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

Office contact: _____
Office phone: (_ _ _) _ _ _ - _ _ _ _
Office fax: (_ _ _) _ _ _ - _ _ _ _
Office email: _____

7-PRESCRIBER AUTHORIZATION†

Prescriber certifies that he/she has obtained consent to release the patient's health information to A·S·A·P in conjunction with the services working solely on behalf of the patient for the purposes of seeking reimbursement through A·S·A·P; verifying insurance coverage; arranging for nursing services; and evaluating the patient's eligibility for alternate sources of funding, patient support services, and materials and product fulfillment via Specialty Pharmacies. The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber. I authorize A·S·A·P to transmit this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

❑ 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, 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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Ascendis Pharma
Patient Authorization Form

I authorize Ascendis Pharma, Inc., its affiliates and the vendors working on Ascendis Pharma, Inc. and its affiliates' behalf (collectively, "Ascendis") and the healthcare providers, pharmacies, insurance companies, third-party payers, or others working on my behalf, to use, share, and store my protected health information (PHI) in order to assess my eligibility for participation in the Ascendis Signature Access Program™ (A·S·A·P), including the audit of my medical records and/or by contacting me directly to confirm my eligibility for participation in A·S·A·P. I understand that Ascendis will use this information in connection with the operation of, and issues related to, A·S·A·P.

I understand that my health information includes information related to my medical condition, treatment, and insurance coverage, as well as identifying information about me (including, for example, my name, address, and date of birth). My health information will be shared with Ascendis so that Ascendis may provide me with various support and information to help me access Ascendis medicine, which may include the following, depending on your program (collectively, "Patient Support Activities"):

- Providing benefits verification and reimbursement support, including:
  - Assistance with identification of my insurer's prior authorization requirements
  - Assistance with identification of my insurer's requirements for appealing a denied claim
- Determining my eligibility for co-pay support or free drug programs
- Providing financial assistance resources and information if I'm eligible
- Sending me a SKYTROFA Auto-Injector and Starter Kit (where appropriate)
- Communicating with my healthcare providers about Ascendis medicine and Patient Support Activities
- Providing me with disease management and other educational materials

Ascendis also may use my health information for quality assurance purposes and to evaluate and improve operations and services.

I understand that I do not have to sign this form, and choosing not to sign will not affect my ability to receive treatment from my healthcare providers or payment from my health insurer. However, if I do not sign this form, A·S·A·P may not be able to provide me with assistance.

I understand the Pharmacy may receive financial remuneration from Ascendis for disclosing PHI to Ascendis and for providing support services to me, including sending communications to me, for purposes of the program as outlined in this authorization.

I understand that once my health information is shared, it may no longer be protected by federal privacy law. However, Ascendis agrees to protect my health information and to use it for the purposes described in this form or as required or permitted by law.

I understand that this authorization will remain in effect until I have notified Ascendis that I have completed my growth hormone treatment (unless a shorter time period is required by state law), or unless I notify both my healthcare provider and Ascendis (at fax number 1-888-436-0193) in writing or at PO Box 1587 Jeffersonville, IN 47131 that I revoke this authorization. This withdrawal will not affect the use or sharing of my health information that took place before I withdraw my approval. I understand I may receive a copy of this form.

Print patient's name _____ Name of legal representative _____

Relationship to patient _____ Signature of legal representative _____ Date _____

❑ I also give my permission to receive communications from Ascendis, A·S·A·P, and parties acting on their behalf, including emails, text messages, or calls made with an autodialer or prerecorded voice at the phone number(s) provided to determine my eligibility and provide benefits information, SKYTROFA Auto-Injector shipment updates, and any other information in support of my access to Ascendis medicine. If I have a caregiver, he or she has also agreed to receive such communications from Ascendis, A·S·A·P, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Ascendis, A·S·A·P, and/or parties acting on their behalf to contact my caregiver for such purposes. I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting A·S·A·P at 1-844-442-7236.

For details about how we collect and use PHI, including applicable US privacy rights and notices for California, Nevada, or Texas residents, please visit https://ascendispharma.us/privacy-policy/.

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