



# SeroCare<sup>SM</sup> STATEMENT OF MEDICAL NECESSITY

Free and confidential patient support for Zorbtive® Fax toll-free to 800-214-8698 or call 800-714-2437 with any questions

## Step 1. Complete Patient Information

Patient Name: \_\_\_\_\_  
 SS#: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female  
 Parent/Legal Guardian: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Preferred contact time and phone number:  Day  Evening  
 Daytime #: \_\_\_\_\_ Okay to leave a message?  Yes  No  
 Evening #: \_\_\_\_\_ Okay to leave a message?  Yes  No  
 E-mail: \_\_\_\_\_

## Step 2. Complete Insurance Information

Primary Insurance: \_\_\_\_\_  
 Cardholder Name: \_\_\_\_\_  
 ID#: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Does patient have a prescription plan?  Yes  No  
 Prescription plan: \_\_\_\_\_  
 ID#: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Phone #: \_\_\_\_\_

## Step 3. Patient Signs Consent

### Authorization for Release of Medical and Insurance Information

In order to participate in EMD Serono's SeroCare<sup>SM</sup> for Zorbtive®, I hereby: (1) authorize EMD Serono, Inc., and any third parties working with EMD Serono (collectively, "EMD Serono") to contact my healthcare provider, pharmacy, insurance company or other third-party payors about my medical, financial, insurance or third party payor information, including but not limited to any confidential HIV-related information, if applicable (my "Information"), and to use and disclose this information, and (2) authorize those parties to disclose (i.e., release) all such Information to EMD Serono. This authorization is permanent unless I notify EMD Serono in writing that I withdraw it. I understand that in order to participate in EMD Serono's program, I also need to sign a separate "Patient Authorization" form concerning the use and disclosure of my Information and I agree to sign that form. I understand that my prescribing physician is responsible for choosing which prescription products are right for me based on my particular diagnosis.

Patient/Legal Guardian  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

## Step 4. Physician Completes Information

Physician: \_\_\_\_\_  
 Office/Clinic/Institution: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 Tax ID#: \_\_\_\_\_ Med. Lic. #: \_\_\_\_\_  
 DEA: \_\_\_\_\_ UPIN#: \_\_\_\_\_

## Step 5. Physician Completes Medical Information

Does the patient have Short Bowel Syndrome?  Yes  No  
 What is the patient's underlying condition?  Intrinsic Bowel disease  Vascular disease  Trauma  Other  
 Has the patient had a bowel resection?  Yes  No Date of surgery: \_\_\_\_\_  
 Length of remaining small intestine:  <90 cm  90-200 cm  >200 cm  
 Is the colon in continuity?  Yes  No Comment \_\_\_\_\_  
 Is the patient receiving parenteral nutrition?  Yes  No  
 If yes, approximate weekly volume: \_\_\_\_\_ (mL) \_\_\_\_\_ days/week  
 Date of parenteral nutrition initiation: \_\_\_\_\_  
 Is the patient on specialized nutritional support other than PN?  Yes  No  
 What is the patient's current weight? \_\_\_\_\_ lbs.

## Step 6. R<sub>x</sub> Physician Completes Prescription Information

Zorbtive® Prescription (dose calculated on body weight at 0.1 mg/kg/day, to a max. of 8 mg/day.)

- Zorbtive® 8.8 mg  
 3 cc syringe, 21 gauge 1-inch needle  
 1 cc insulin syringe with 29-31 gauge 3/8" needle for injection  
 Prescribed Dose: \_\_\_\_\_ milligrams per day for 28 days

Zorbtive® Dosing Algorithm		
Kilograms	Pounds	Dose (mg)
≥ 75	≥ 165	≥ 8.0
65 - 74.9	143 - 164.9	7.0
55 - 64.9	121 - 142.9	6.0
45 - 54.9	99 - 120.9	5.0
35 - 44.9	77 - 98.9	4.0

Electronically transmitted prescriptions are valid for 1 year.

**Physician Certification:** I certify that the prescribed therapy is medically necessary for the treatment of Short Bowel Syndrome, that the information in this SMN is accurate to the best of my knowledge, and that I am aware of the risks and benefits associated with the use of Zorbtive®. I authorize EMD Serono to be my designated agent (1) to provide any information on this form to the insurer of the named patient and (2) forward the above prescription, by fax or by other mode of delivery to the pharmacy chosen by the named patient.

Physician's Name \_\_\_\_\_ Date: \_\_\_\_\_  
(please print)  
 Address: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 X \_\_\_\_\_

# Patient Authorization

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

SS # \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_

## Authorization to use and disclose medical, financial and insurance information.

I confirm that I want to participate in EMD Serono's SeroCare<sup>SM</sup> for Zorbtive<sup>®</sup>. By signing below, I hereby:

- 1) authorize EMD Serono, Inc., and any third parties working with EMD Serono, including but not limited to McKesson Speciality which helps administer EMD Serono's SeroCare<sup>SM</sup> program, (collectively, "EMD Serono") to contact my healthcare provider, pharmacy, insurance company or other third-party payors (collectively, "Third Parties") about my medical, financial, insurance or third party payor information, including but not limited to any confidential HIV-related information, if applicable, and information to verify the accuracy of the information I provide in my application or related to my enrollment or participation in EMD Serono's program (my "Information") for the purposes described below, and
- (2) authorize the Third Parties to use and disclose (i.e., to release) all such Information to EMD Serono for the purposes described below, and
- (3) authorize EMD Serono to use and disclose my Information for those same purposes; and



- (4) authorize EMD Serono to disclose Information back to the Third Parties for those same purposes; and
- (5) authorize EMD Serono and Third Parties to disclose Information about me between and among each other for those same purposes.

## Purposes for which your Information may be used and disclosed

By signing below, I authorize the use and disclosure of my Information (which includes any confidential HIV-related information, if applicable), for the following purposes:

- to enroll me in EMD Serono's program;
- to provide me with free medical and clinical information and patient educational materials about my condition, treatment options, products and program offerings;
- to assist me in obtaining insurance coverage for my prescription drug, including support for appeals and help with required documentation needed by insurance companies, and provide me with information about alternative payment options, including any applicable patient assistance programs;
- to help me locate a pharmacy to fill my prescription, if applicable, and to facilitate dispensing of my prescription;
- to provide me with any necessary delivery device and related supplies;
- to provide me with training by a nurse on how to use any necessary delivery device;

- to provide me with information about compliance with the treatments my healthcare provider has prescribed and to have nurses follow-up with me about my treatment compliance;
- to monitor the status of my insurance reimbursement, prescription dispensing, device delivery and training, and treatment compliance and advise my healthcare provider, pharmacy, insurance company or other third-party payors of such status;
- to conduct surveys to measure my patient satisfaction with the program and dispensing and delivery of my prescription and delivery device; and
- for such other purposes as may be required or permitted by applicable law.

**Authorization to forward prescription to pharmacy**

By signing below, I authorize EMD Serono and the Third Parties to send, via fax or other mode of delivery, my prescription to the pharmacy of my choosing.

**Terms of this Authorization**

This authorization has no expiration date. It is a permanent authorization (unless and until it is revoked). I understand that: (1) I can revoke this authorization by notifying EMD Serono in writing and the revocation is not effective as to actions any party took in reliance on the authorization, (2) once my Information is disclosed to third parties under this authorization some of it may not be protected, (3) I can refuse to sign this form (but then I can't participate in the program), (4) EMD Serono reserves the right to, at any time and without notice: (a) modify the application form and the eligibility criteria, (b) modify or discontinue

any or all aspects of the program, and (c) terminate any assistance provided by the program, (5) I have the right to receive a copy of this form and (6) my prescribing physician is responsible for choosing which prescription products are right for me based upon my particular diagnosis.

Check this box for more information

I authorize EMD Serono and the Third Parties to send me up-to-date medical and promotional information on my prescription drug and additional EMD Serono programs, services and products which may be of interest to me.

Signature of patient or legal guardian:

\_\_\_\_\_

Date: \_\_\_\_\_

