OmniSource®

Patient Authorization

Omnitrope®
(somatropin [rDNA origin] for injection)

To provide patient authorization for OmniSource services, please fill out form completely and **fax to 877.828.1052**.

Patient Name ______________________________

Parent/Legal Guardian Name (if applicable) ____________________ Relationship to Patient ____________

Address ____________________ City ____________ State ______ ZIP ________

Home Phone ____________ Work or Cell Phone ____________ E-mail ____________

Please read the following carefully:

Patient Authorization

I give permission for my healthcare providers, pharmacies, health insurer(s), third-party contractors, and service providers to disclose my personal health information ("Personal Information"; as noted on the Statement of Medical Necessity), including information about my insurance, prescriptions, medical condition, and health to Sandoz, as well as to its affiliates and contractors who have been hired to administer the OmniSource Patient Support Program, so that Sandoz can (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with Omnitrope, (ii) coordinate my receipt of, and payment for Omnitrope, (iii) facilitate my access to the OmniSource Patient Support Program, (iv) provide me with information about Omnitrope, disease awareness and management programs, and educational materials, (v) manage the OmniSource Patient Support Program, (vi) provide me with adherence reminders and support, and (vii) conduct quality assurance, surveys, and other internal business activities in connection with the OmniSource Patient Support Program. Additionally, I give permission to Sandoz contractors who have been hired to administer the OmniSource Patient Support Program to use and/or disclose, as needed, my Personal Information, in order to coordinate the receipt, payment, and proper administration of Omnitrope as prescribed by my healthcare provider.

I give permission to Sandoz to disclose my Personal Information to my healthcare providers, pharmacies, health insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above. I understand that my pharmacies, health insurer(s), and healthcare providers may receive remuneration (payment) from Sandoz in exchange for disclosing my Personal Information to Sandoz and/or for providing me with therapy support services.

I understand that once my Personal Information is disclosed, it may no longer be protected by federal privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization at any time in the future by calling 877.456.6794. My refusal or future revocation will not affect the commencement or continuation of my treatment by my healthcare providers; however, if I revoke authorization, I may no longer be eligible to participate in the OmniSource Patient Support Program. If I revoke this authorization, Sandoz will stop using or sharing my Personal Information (except as necessary to end my participation in the program), but my revocation will not affect uses and disclosures of my Personal Information previously disclosed in reliance upon this authorization.

I understand that this authorization will remain valid for five (5) years after the date of my signature, unless I revoke it earlier. I also understand that the OmniSource Patient Support Program may change or end at any time without prior notification. I understand that I may receive a copy of this authorization.

I agree to be contacted by Sandoz by mail, e-mail, telephone calls, and text messages at the number(s) and address(es) provided on the Patient Authorization Form for all purposes described in this Patient Authorization. I also agree to be contacted by Sandoz and on its behalf by telephone calls and text messages made by using an automatic telephone dialing system or prerecorded voice at the number(s) provided on the Patient Authorization Form for all non-marketing purposes, including but not limited to, sending me materials and asking for my participation in surveys. I confirm that I am the subscriber for the telephone number(s) provided and the authorized user for the e-mail address(es) provided, and I agree to notify Sandoz promptly if any of my number(s) or address(es) change in the future. I understand that my wireless service provider's message and data rates may apply.

I understand that Sandoz does not permit my Personal Information to be used by its business partners for their own separate marketing purposes. I understand and agree that Personal Information transmitted by e-mail and cell phone cannot be secured against unauthorized access.

Co-Pay Program Terms and Conditions

OmniSource has a Co-Pay program for eligible patients prescribed Omnitrope. The Omnitrope Co-Pay Savings Program provides up to $5,000 in annual Co-Pay support for Omnitrope prescriptions. With the Omnitrope Co-Pay Savings Program, eligible patients may pay $0 for their Co-Pay. Eligible patients who are commercially insured may receive co-pay support in the amount of up to $5,000 annually and patients who are uninsured may receive co-pay support in the amount of up to $417 monthly, with an annual cap of $5,000. Prescription must be for an approved indication. This program is not health insurance. Patients are not eligible if prescriptions are paid, in whole or in part, by any state or federally funded programs, including but not limited to Medicare (including Part D, even in the coverage gap) or Medicaid, Medigap, VA, DOD, or TriCare, or private indemnity, or HMO insurance plans that reimburse you for the entire cost of your prescription drugs, or where prohibited by law. Patients can participate for a maximum of 12 months. Eligible patients must have a first use of the program by December 31 of the current year. Omnitrope Co-Pay Savings Program may not be combined with any other rebate, coupon, or offer. Sandoz reserves the right to rescind, revoke, or amend this offer without further notice.

I have read and agree to the Patient Authorization and Co-Pay Program Terms and Conditions.

Patient/Parent/Legal Guardian Signature ______________________________ Date ____________

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S-OMN-1336828 10/2016

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