

Patient Information

Patient Name (First and Last) _____
Address _____
City _____ State _____ ZIP _____
Home Phone _____ Work Phone _____
Referring Physician _____

Date of Birth _____
Social Security Number _____
Allergies None Other _____
Gender M F Primary Language _____
Specialty _____

**Insurance Information/
Attach Copy
of Insurance
Card**

Physician Provider/Tax ID # _____
Primary Insurance _____
Insurance Company Phone _____
Subscriber _____ DOB _____
Subscriber ID # _____
Policy/Employer/Group # _____

Office Contact _____
Secondary Insurance _____
Insurance Company Phone _____
Subscriber _____ DOB _____
Subscriber ID # _____
Policy/Employer/Group # _____

Diagnosis

ICD-9 Code 253.0 Other (specify by ICD-9): _____

Medical Assessment

Serum IGF-I Test
Date: _____ Result: _____
Normal Range: _____

**Prescription
Options for
SOMAVERT**

Loading dose (subcutaneous injection):
 40-mg loading dose _____ Other (mg) loading dose _____
Dose titration (subcutaneous injection):
 10 mg/day 15 mg/day 20 mg/day
 25 mg/day 30 mg/day Other: ____ mg/day
Days supply: _____ Refills: _____ Start date: _____

Include syringes:
Administration: 1-cc insulin syringe 29 g, 1/2"
Reconstitution: 1-cc diluent syringe 21 g, 1"

**Additional
Information**

**Physician
Certification**

1) I certify that the treatment listed above is and will be medically necessary based on my best professional judgment, and that the information provided above is complete and accurate to the best of my knowledge. **2)** I also certify that I have obtained the written permission of the patient (or the patient's legal representative) to disclose the information here and such other health or personal information to the Pfizer Bridge Program™ ("the Program"), Pfizer, and/or its agents as may be necessary for the patient's participation in the Program. (A signed copy of a Pfizer Bridge Program™ Patient Authorization Form ["the Authorization"] either accompanies this completed Statement of Medical Necessity or, to the best of the undersigned's knowledge, is already on file with the Pfizer Bridge Program™.) I understand that the Program may use and disclose this information only in accordance with the Authorization. **3)** I further certify that (a) any service provided through the Pfizer Bridge Program™ on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use Somavert® or any other Pfizer product or service for anyone, and (b) my decision to prescribe Somavert was based on my determination of medical necessity as set forth herein.

Signature* _____ Date _____
Print Name _____ DEA # _____
Address _____ City _____ State _____ ZIP _____
Phone _____ Fax _____

*This form cannot be processed without physician's signature.