SUSPECT ADVERSE REACTION REPORT

I. REACTION INFORMATION

1. PATIENT INITIALS (first, last)	1a. COUNTRY	2. DATE OF BIRTH			2a. AGE	3. SEX	3a. WEIGHT	4-6 REACTION ONSET		
		Day	Month	Year				Day	Month	Year
PRIVACY	GUATEMALA		PRIVACY		Unk	Female	Unk		Unk	

8-12 CHECK ALL APPROPRIATE TO ADVERSE REACTION

7 + 13 DESCRIBE REACTION(S) (including relevant tests/lab data)
Event Verbatim [LOWER LEVEL TERM] (Related symptoms if any separated by commas)

device stopped working [Device defective]

Case Description: This is a spontaneous report received from a Consumer or other non HCP from medical information team and product quality group.

A female patient received somatropin (GENOTROPIN PEN), (Batch/Lot number: unknown). The patient's relevant medical history and concomitant medications were not reported.
The following information was reported: DEVICE DEFECTIVE (non-serious), outcome "unknown", described as "device stopped working".

(Continued on Additional Information Page)

- ☐ PATIENT DIED
- ☐ INVOLVED OR PROLONGED INPATIENT HOSPITALISATION
- ☐ INVOLVED PERSISTENT OR SIGNIFICANT DISABILITY OR INCAPACITY
- ☐ LIFE THREATENING

II. SUSPECT DRUG(S) INFORMATION

14. SUSPECT DRUG(S) (include generic name)
#1) Genotropin Pen (SOMATROPIN) Solution for injection
#2) Genotropin Pen (SOMATROPIN (DEVICE CONSTITUENT)) Solution for injection

20. DID REACTION ABATE AFTER STOPPING DRUG? ☐ YES ☐ NO ☒ NA

15. DAILY DOSE(S)	16. ROUTE(S) OF ADMINISTRATION
#1)	#1) Unknown
#2)	#2) Unknown

17. INDICATION(S) FOR USE
#1) Unknown
#2) Unknown

21. DID REACTION REAPPEAR AFTER REINTRODUCTION? ☐ YES ☐ NO ☒ NA

18. THERAPY DATES(from/to)	19. THERAPY DURATION
#1) Unknown	#1) Unknown
#2) Unknown	#2) Unknown

III. CONCOMITANT DRUG(S) AND HISTORY

22. CONCOMITANT DRUG(S) AND DATES OF ADMINISTRATION (exclude those used to treat reaction)

23. OTHER RELEVANT HISTORY. (e.g. diagnostics, allergies, pregnancy with last month of period, etc.)

From/To Dates	Type of History / Notes	Description
Unknown		

IV. MANUFACTURER INFORMATION

24a. NAME AND ADDRESS OF MANUFACTURER
Pfizer S.A.
Laura Arce Mora
Avenida Escazú, Torre Lexus, piso 7. Escazú
San jose, COSTA RICA

26. REMARKS

24b. MFR CONTROL NO.
202500100430

25b. NAME AND ADDRESS OF REPORTER
NAME AND ADDRESS WITHHELD.

24c. DATE RECEIVED BY MANUFACTURER
13-MAY-2025

24d. REPORT SOURCE
☐ STUDY ☐ LITERATURE ☐ HEALTH PROFESSIONAL ☒ OTHER: Spontaneous

DATE OF THIS REPORT
22-MAY-2025

25a. REPORT TYPE
☒ INITIAL ☐ FOLLOWUP:

ADDITIONAL INFORMATION

7+13. DESCRIBE REACTION(S) continued

Causality for "device stopped working" was determined associated to device constituent of somatropin (malfunction).

The information on the batch/lot number for somatropin, somatropin will be requested and submitted if and when received.