



STATEMENT OF MEDICAL NECESSITY

Fax this completed SMN form and attached patient authorization form, toll-free, with supporting documentation, including copy of patient's insurance card(s), to Fax: 1-800-548-7036. Or call 1-866-TERCICA (837-2422) with any questions and press option #2, then option #3.

Information to Be Completed by Prescriber

Prescriber _____
Office/Clinic/Institution _____
Street Address _____
City _____ State _____ ZIP _____
Phone _____ Fax _____
Tax ID # _____ Medicaid Provider # _____
DEA _____ NPI # _____
BCBS Provider # _____
Office Contact: Name and number _____

PATIENT MEDICAL HISTORY

Diagnosis (select one) Secondary Diagnosis
 Severe Primary IGFD _____
 Growth Hormone Gene Deletion _____
 Other _____
ICD-9-CM (select one) _____
 783.43 Short Stature/Growth Failure _____
 Other _____

Important: Please remember to check both a Diagnosis and ICD-9 code.

Has patient received prior growth hormone therapy? Yes No
If "Yes," please provide name of product _____
Duration _____ and Last Dose _____ (mg/day)
Any Allergies _____

Medical Assessment

Current Height _____ cm (ft/in) _____ percentile
Growth Velocity _____ cm/yr
Current Weight _____ kg (lb)
Skeletal X-ray Date _____ Bone Age _____ yr _____ mo
Chronological Age _____
Epiphyses Open? Yes No

IGF-1 Levels

Results _____ ng/mL
Lab Reference Range _____ age/sex

Growth Hormone Stimulation Test

Date _____ Agent 1 _____
Peak _____
 Patient has neutralizing antibodies to growth hormone
IGFBP3 Test Results: _____
Thyroid Function Test Results: _____

Attached are copies of: Growth chart Other relevant patient medical history

Patient Information

Patient Name _____
DOB _____ Male Female Social Security # _____
Parent/Legal Guardian _____
Street Address _____
City _____ State _____ ZIP _____
Daytime Phone _____ Evening Phone _____
Cell Phone _____ E-mail _____

INSURANCE INFORMATION

Primary Insurance _____
 Check here if you have secondary insurance
Cardholder Name _____
ID # _____ Group # _____
Phone # _____
Does patient have a prescription plan? Yes No
Prescription plan _____
ID # _____ Group # _____
Phone # _____

Important: Attach copy, front and back, of patient's PRIMARY and SECONDARY insurance card(s).

CONSENT AND AUTHORIZATION TO BE READ AND SIGNED BY PATIENT

Authorization for Release of Medical and Insurance Information

I hereby authorize my healthcare providers, health insurers and designated pharmacies who provide services to me to disclose to Tercica, Inc., its personnel and/or agents (collectively, "Tercica") all medical records, insurance or third-party payer information, and financial information which is to be used in obtaining reimbursement coverage for Increlex®. I further authorize the designated Specialty Pharmacy that receives my prescription for Increlex® to release and communicate to Tercica any and all information about my prescription for and my use of Increlex® so that Tercica may continue to provide me with products, supplies and/or services throughout the TerciCare™ program, aggregate data, conduct market analysis and provide me with educational and additional information regarding Increlex®. I also authorize Tercica to enroll me in the TerciCare™ program. I understand that this enrollment form will be sent to TerciCare™ so I may be enrolled and that someone from TerciCare™ will contact me soon about the program. I understand that this information, once released, may be redisclosed by Tercica. I also understand that receipt of Increlex® is not conditional on my signing this authorization. I further understand that this authorization is revocable by me in writing, except to the extent action has been taken in reliance on it, by giving written notice to TerciCare™, c/o Tercica, 2000 Sierra Point Parkway, Suite 400, Brisbane, CA 94005. Unless revoked by me in writing, this authorization will be effective until December 31, 2010.

- I have also read and signed the attached patient authorization form.
- Please contact me regarding up-to-date information on Increlex and additional Tercica programs and services.

X _____ Date _____
(Parent/Legal Guardian Signature)

Rx and Statement of Medical Necessity to Be Completed and Signed by Prescriber

Prescription Increlex® (mecasermin [rDNA origin] injection) (40 mg/4 mL vial)

New Start Continued Tx Restart Tx
weight in kg _____ x 0.04 mg/kg = _____ mg dose BID SQ or _____ units BID for _____ days then increase to
weight in kg _____ x 0.08 mg/kg = _____ mg dose BID SQ or _____ units BID for _____ days then increase to
weight in kg _____ x 0.12 mg/kg = _____ mg dose BID SQ or _____ units maintenance dose until next appointment
Follow-up Evaluation Every _____ Months; Next Planned Visit _____
Therapy Start Date _____; # of refills _____; Dispense as written

Increlex
J-Code: J2170

Injection training to be conducted in:

- Office (by office staff) Office (Coordinated by TerciCare or Pharmacy)
- Home (Coordinated by TerciCare or Pharmacy) TerciCare Clinic

Would you like us to provide the following:

Starter Therapy* *excluding Medicaid and MA* Yes No
Ship to: Patient Physician
Inject-Ease® Yes No
Syringes for Injection .50 cc _____ Quantity
 1 cc _____ Quantity
*Maximum 8 months

Please call 1-866-TERCICA (837-2422) with any questions and press option #2 then option #3, or fax 1-800-548-7036.

Prescriber Certification

I certify that the prescribed therapy is medically necessary and that this information is accurate to the best of my knowledge. I authorize Tercica to be my designated agent (1) to provide any information on this form to the insurer of the named patient and (2) to forward the above prescription, by fax or other mode of delivery, to the pharmacy chosen by the named patient.

It is the prescriber's responsibility to ensure the proper coding, accuracy, and completeness of the description of the patient's medical history.

Prescriber's Name _____ Date _____
(Please print)
X _____ Date _____
(Prescriber Signature) This form cannot be processed without prescriber signature.