

Statement of Medical Necessity

Patient Demographic & Insurance Information

Patient Name: _____ Date: _____
 DOB: _____ Male Female
 Parent/Legal Guardian: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home phone: _____ Cell phone: _____
 Fax: _____ E-mail: _____

Primary Insurance: _____ Phone: _____
 Subscriber name: _____
 Subscriber ID #: _____ Group#: _____
 Secondary Insurance: _____ Phone: _____
 Subscriber ID #: _____ Group#: _____
 Does patient have a prescription plan? Yes No
 Prescription plan: _____ Phone: _____
 ID#: _____ Group#: _____

Important: Attach copy (front & back) of insurance card(s).

Information to Be Completed by Prescriber

For Physician Use Only:

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

Patient Medical History

Primary Diagnosis (select one):
 Severe Primary IGF1
 Growth Hormone Gene Deletion
 Other _____
 Secondary Diagnosis: _____
 ICD-9-CM (select one):
 783.43 Short Stature/Growth Failure
 Other: _____
 Important: Please 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)
 List Allergies: _____ NKA

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

Complimentary Support Services:

Would you like a nurse from the **Ipsen Nurse Network** to conduct injection training? Yes No, my staff will conduct the training
 If yes, I request that training be conducted: In home In office
Ipsen Nurse Network nurse preference: _____
 A Home Health nurse will conduct training if an **Ipsen Nurse Network** nurse is unavailable.

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

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

Ship to: Physician Office Patient Home

New Start Continued Tx Restart Tx

Weight in kg: _____ x0.04 mg/kg= _____ mg dose BID SQ or _____ units BID for _____ days then increase to

Weight in kg: _____ x0.08 mg/kg= _____ mg dose BID SQ or _____ units BID for _____ days then increase to

Weight in kg: _____ x0.12 mg/kg= _____ mg dose BID SQ or _____ units maintenance dose until next appointment

Dispense: _____ 1 month supply _____ 3 months supply _____ other: _____ months supply _____ # of refills Dispense as Written

Follow-up Evaluation Every _____ Months Next planned visit _____ Therapy Start Date _____

Inject-Ease® Yes No Syringes for injection .50cc _____ Qty 1cc _____ Qty

Patient Starter: Would you like us to provide Starter Therapy? Yes No (excluding Medicaid and MA)

Prescriber Declaration: I certify that the prescribed therapy is medically necessary and that this information is accurate to the best of my knowledge. I further certify that (a) any service provided through the PACE 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 Increlex or any other Ipsen product or service for anyone and (b) my decision to prescribe Increlex was based on my determination of medical necessity as set forth herein. I authorize Ipsen 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.

Physician's Signature _____ Date _____

Patient Authorization To Use/Disclose Health Information

I authorize my healthcare providers (including those specialty pharmacies that receive my prescription for Increlex[®]) and my health plans to disclose personal and medical information about me to Tercica, Inc. (a subsidiary of the Ipsen Group), its agents and contractors including nursing agencies who work with the PACE program (collectively "Ipsen") to enroll me in the Patient Access, Care & Education (PACE) Program to: (1) establish my benefit eligibility; (2) communicate with my healthcare providers and health plans about my medical care; (3) provide support services including patient education and helping to get Increlex to me; and (4) to evaluate the effectiveness of Ipsen's educational programs and to conduct market analysis, including aggregating my health information (with personally identifying information deleted) with other data for such analysis. I agree that using the contact information I provide, Ipsen may get in touch with me for reasons related to the PACE program and may leave message for me that may disclose that I take Increlex.

I understand that once my health information has been disclosed to Ipsen, privacy laws may no longer restrict its use or disclosure; however, Ipsen agrees to protect my information by using and disclosing it only for the purposes described above or as required by law. I further understand that I may refuse to sign this Authorization and if I do not sign it, my eligibility for health plan benefits and treatment (including the receipt of Increlex) will not change, but I will not have access to the PACE Program support services described above.

I may revoke (cancel) this Authorization at any time by mailing a letter requesting such revocation to: PACE c/o Ipsen, 2000 Sierra Point Parkway, Suite 400, Brisbane CA 94005. If I cancel, Ipsen will stop using or disclosing my information for the purposes licensed above, except as required by law or as necessary for the orderly termination of my participation in the PACE program. However, revoking this Authorization will not affect the ability of Ipsen to use and disclose information that it has already received. I understand that I am entitled to a copy of this Authorization which expires on December 31, 2028.

Signature of Parent/Legal Guardian

Date

Print name of Parent or Legal Guardian

Relationship to Patient

Marketing Program "Opt-In"

I authorize Ipsen to enroll me in Increlex Patient Marketing Programs. I understand that my personally identifiable information related to IGFD and my treatment with Increlex is required for participation in the support program. In addition to the information that I provide directly to the program, I understand that any personal information that I have provided will be shared between PACE and the Increlex Patient Marketing Programs.

I understand that my personally identifiable information will be shared with Ipsen, their agents and affiliates, and my healthcare provider. I agree that I may be contacted in the future by mail, e-mail, and/or telephone concerning the Increlex Programs. The information you provide to us will be shared with and among our business partners, affiliates, and agents to provide you with information, products, programs, and services, and to conduct market research.

I understand that I do not have to sign this authorization in order to receive Increlex or to be eligible for the assistance from the PACE Program and that I may cancel this authorization at any time by mailing a letter to Increlex Patient Marketing Programs, 2000 Sierra Point Parkway, Suite 400, Brisbane, CA 94005.

This Authorization expires December 31, 2028.

Signature of Parent/Legal Guardian

Date

E-mail

Primary Phone



Phone: 1-866-435-5677 Fax: 1-888-525-2416

©2009 Ipsen, Inc.,