



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 #3.

Information to Be Completed by Prescriber

Prescriber _____
Office/Clinic/Institution _____
Street Address _____
City _____ State _____ ZIP _____
Phone _____ Fax _____
Med. Lic. # _____
DEA _____ UPIN # _____

PATIENT MEDICAL HISTORY

Diagnosis

- Severe Primary IGFD
- Growth Hormone Gene Deletion
- Other _____

ICD-9-CM

- Short Stature/Growth Failure 783.43
- Dwarfism, Not Elsewhere Classified 259.4
- Unspecified Endocrine Disorder 259.9
- Other _____

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

Medical Assessment

Current Height _____ cm (ft/in) _____ percentile
Growth Velocity _____ cm/yr
Predicted Adult Height _____ cm
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 _____
Date _____ Agent 2 _____
Peak _____

MRI or CT Test Results: _____
IGF-BP3 Test Results: _____
Karyotype Results: _____
Thyroid Function Test Results: _____

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

Information to Be Completed by Patient

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 conditioned 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
Dose per Injection _____ mcg/kg; _____ units
Frequency/day _____ Times/week _____
Follow-up Eval. Every _____ Months Next Planned Visit _____
Therapy Start Date _____
Injection Training to Be Completed by:
 Office (by office staff) Home (Coordinated by TerciCare or Pharmacy)

Would you like for us to provide the following:

Sample Rx Yes No
Ship to: Physician Patient (Excluding Medicaid and MA)
Inject-Ease® Yes No
Syringes for Injection .50 cc _____ Quantity

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

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.