Somatuline® Depot (lanreotide) Injection

Referral, Consent, and Physician Orders

I. PATIENT DEMOGRAPHIC INFORMATION

Name: ______________________ Date: __________

SSN: ______________________ DOB: __________

Address: ______________________

City: ______________________ State: ________ ZIP: ________

Home phone: ______________________ Cell phone: ______________________

II. INSURANCE AND COPAYMENT INFORMATION

Primary: ______________ Subscriber: ______________

Subscriber ID: ______________ Group #: ______________

Secondary: ______________ Subscriber: ______________

Subscriber ID: ______________ Group #: ______________

What product were you taking to treat acromegaly? ______________________

What specialty or retail pharmacy was fulfilling the prescription? ______________________

Was it a medical or pharmacy benefit? ______________________

What was the estimated copay? ______________________

III. 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 that is to be used in obtaining reimbursement coverage for Somatuline® Depot. I further authorize the designated specialty pharmacy that receives my prescription for Somatuline® Depot to release and communicate to Tercica any and all information about my prescription for and my use of Somatuline® Depot 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 Somatuline® Depot. 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 the receipt of Somatuline® Depot 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 Pointe 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 Somatuline® Depot and additional Tercica programs and services.

______________________ ______________

Patient signature Date

For Physician Use Only:

IV. PHYSICIAN DEMOGRAPHIC INFORMATION

Prescriber: ______________________

Clinic or office name: ______________________

Address: ______________________

City: ______________________ State: ________ ZIP: ________

Office contact: ______________________

Phone: ______________________ Fax: ______________________

NPI #: ______________________ UPIN #: ______________________

DEA #: ______________________ State license #: ______________________

Issued: Month______________ Date______________ Year______________

V. MEDICAL INFORMATION

Diagnosis: ☐ Acromegaly/gigantism (253.0) ☐ Other: ______________________

Allergies: ☐ NKA ☐ List allergies: ______________________

☐ Pregnant ☐ Diabetes ☐ Kidney or liver disease

☐ Heart disease (heart valve disease)

☐ Surgery or ☐ Radiotherapy have been ineffective or inappropriate

Other pertinent history? ______________________

Where would your patient like to have their injection administered?

☐ Office ☐ Home

Would your patient like to receive injection training from ActiveCare™?

☐ Yes ☐ No

Ship to: ☐ Clinic ☐ Physician ☐ Patient home

Note: Patients with acromegaly, excluding those on Medicare or Medicaid and residents of MA, are eligible to receive free injections for up to 8 months or until insurance coverage begins.

VI. PRESCRIPTION INFORMATION

Prescription: Somatuline® Depot (lanreotide) Injection

Strength: ☐ 60 mg ☐ 90 mg ☐ 120 mg

Route: Deep subcutaneous

Frequency: ☐ Every 28 days ☐ Other: ______________________

Quantity: ______________ # of refills: ______________

Special instructions: ______________________

VII. SOMATULINE® DEPOT HISTORY:

Patient ☐ has ☐ has not received Somatuline® Depot previously

Date of last dose: ______________ Dose rec'd: ______________ mg

Date of next or first scheduled injection: ______________________

Prescriber Declaration: I verify that the patient and prescriber information contained in this form is complete and accurate to the best of my knowledge and that I have prescribed Somatuline® Depot based on my professional judgment of medical necessity. I authorize Tercica, its affiliated companies, or subcontractors to perform any steps necessary to obtain reimbursement for Somatuline® Depot and to forward this prescription electronically, by facsimile, or by mail to a dispensing pharmacy chosen by or for the above-named patient.

______________________ ______________

Physician signature Date

Phone: 1-866-TERCICA (837-2422)

Fax: 1-800-548-7036

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