Genentech ACCESS SOLUTIONS®
A Member of the Roche Group

Prescriber Service Form

SUBMIT ONLY REQUESTED DOCUMENTS

Required field (*)

Step 1 Patient Information

SERVICES REQUESTED
(CHECK ALL THAT APPLY):

- ☐ **Benefits Investigation (BI) & Prior Authorization (PA) Support**
  - ☐ Re-verify benefits at PA expiration
- ☐ **Co-Pay Referrals**
  - Genentech Co-Pay Card
  - Co-Pay Assistance Foundation
- ☐ **Appeals Support**

If you believe your patient is eligible for free medicine, call Genentech Patient Foundation at (888) 941-3331

*FIRST NAME: _____ *LAST NAME: _____

*DATE OF BIRTH (MM.DD.YYYY): ___/___/_____ *GENDER: ☐ MALE ☐ FEMALE

*STREET: _____ APT: _____

*CITY: _____ *STATE: _____ *ZIP: _____

PHONE: (_____) _____-_____ PHONE TYPE: ☐ CELL ☐ HOME

☐ DO NOT CONTACT PATIENT EMAIL: _____

PATIENT PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER: _____

ALTERNATE CONTACT NAME: _____

RELATIONSHIP: _____ ALT PHONE: (_____) _____-_____

Step 2 Insurance Information

Please fill out information below or attach insurance cards

☐ **See copy of insurance cards**

Is the patient insured? ☐ Yes ☐ No

Is PA in place? ☐ Yes ☐ No AUTH #: _____

	PRIMARY INSURANCE	SECONDARY INSURANCE	PHARMACY BENEFIT
INSURANCE NAME			
SUBSCRIBER NAME (IF NOT PATIENT)			
SUBSCRIBER ID			
POLICY/GROUP #			
INSURANCE PHONE #			

Step 3 Patient's Therapy (check all that apply)

Infused and Subcutaneous (SC) Therapy

- ☐ Avastin® (bevacizumab)
- ☐ GAZYVA® (obinutuzumab)
- ☐ Herceptin® (trastuzumab)
- ☐ Herceptin HYLECTA™ (trastuzumab and hyaluronidase-oysk)
- ☐ KADCYLA® (ado-trastuzumabemtansine)
- ☐ PERJETA® (pertuzumab)
- ☐ POLIVY™ (polatuzumab vedotin-piiq)
- ☐ RITUXAN® (rituximab)
- ☐ RITUXAN HYCELA® (rituximab/hyaluronidase human)
- ☐ TECENTRIQ® (atezolizumab)

Oral Therapy (Complete page 3 prescription)

- ☐ ALECENSA® (alectinib)
- ☐ COTELLIC® (cobimetinib)
- ☐ Erivedge® (vismodegib)
- ☐ ROZLYTREK™ (entrectinib)
- ☐ Tarceva® (erlotinib)
- ☐ Zelboraf® (vemurafenib)
- ☐ XELODA® (capecitabine)

For XELODA requests, attach prescription

List Medications used in combination with Genentech therapy for a regimen benefits investigation

☐ **See attached Medication List**

REGIMEN NAME: _____

MEDICATIONS/DOSING OR BILLING CODES: _____

Where will infused or subcutaneous medication(s) be provided?

☐ Physician's office ☐ Hospital Outpatient Department ☐ Other (please specify)*

NAME: _____

TAX ID: _____ NPI‡ #: _____

Oral Therapy Dispensed through:

☐ Onsite Pharmacy ☐ Specialty Pharmacy (SP)

PREFERRED SP: _____

Please **continue to Step 4** on the next page

‡National Provider Identifier.

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Required field (*)

Step 4 Patient Information (please re-enter)

*FIRST NAME: _____ *LAST NAME: _____ *DOB (MM.DD.YYYY): ___/___/_____

Step 5 Diagnosis and Clinical Information

To the highest level of specificity, provide:

*PRIMARY DIAGNOSIS CODE: _____

SECONDARY DIAGNOSIS CODE: _____

Has the patient started therapy? ☐ Yes ☐ No DATE OF TREATMENT: ___/___/_____

Line of therapy: ☐ First ☐ Second ☐ OTHER: _____

HER2 positive? ☐ Yes ☐ No

PD-L1 positive? ☐ Yes ☐ No

Neo-Adjuvant: ☐ Yes ☐ No

Adjuvant: ☐ Yes ☐ No

Clinical TNM stage:

☐ 0 ☐ IIA ☐ IIIA ☐ IIIC

☐ I ☐ IIB ☐ IIIB ☐ IV

Previous treatment:

☐ None ☐ Radiation ☐ Hormone Therapy ☐ Surgery

☐ OTHER (IF CHEMOTHERAPY, PLEASE SPECIFY): _____

Step 6 Prescriber Information

*FIRST NAME: _____ *LAST NAME: _____

*PRACTICE NAME: _____

*STREET: _____ SUITE: _____

*CITY: _____ *STATE: _____ *ZIP: _____

PRESCRIBER TAX ID #: _____ PRESCRIBER NPI‡ #: _____ GROUP NPI‡ #: _____

OFFICE CONTACT: _____ OFFICE CONTACT EMAIL: _____

OFFICE CONTACT PHONE: (_____) _____ - _____ OFFICE CONTACT FAX: (_____) _____ - _____

Step 7 Health Care Provider Certification

By submitting this form, I certify:

(a) The above therapy is medically necessary for this patient and the treatment decision has been made by the prescribing physician.
(b) If the indication for which this Genentech product is being prescribed to treat is not listed in the FDA-approved label, the prescriber is prescribing the medication for an "unapproved" use, meaning that the FDA has not approved the efficacy, dosage amount or safety of this medication for such a use.
(c) The provider's office received the authorization to release the information above and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc., Genentech Access Solutions, the contracted dispensing pharmacy, or other contractors for the purpose of requesting reimbursement support, assisting in initiating or continuing therapy, as a break in treatment would negatively impact the patient's therapeutic outcome.
(d) The provider's office will not attempt to seek reimbursement for free product provided to the patient.
(e) The services requested on behalf of the patient may include benefits investigation (BI), benefits re-verification, prior authorization (PA) and appeals support, co-pay card and co-pay assistance foundation referral. In the absence of a checkbox selecting a service, Genentech Access Solutions will perform BI/PA services on behalf of the patient.
(f) No action on these services will be taken until the patient consent document has been received.

- If you are seeking support for Infused or SC therapy, **fax pages 1 & 2 to (888) 249-4919**
- If you are seeking support for Oral or Starter therapy, please **continue to page 3**

 ‡National Provider Identifier.

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Prescriber Service Form

SUBMIT ONLY REQUESTED DOCUMENTS

ORAL PRODUCTS ONLY - Complete all fields for prescribed therapy

Step 8 Patient Information (please re-enter)

*FIRST NAME: _____ *LAST NAME: _____ *DOB (MM.DD.YYYY): ___/___/_____

Step 9 Prescription Information

For ALECENSA® (alectinib) patients

Metastatic non-small cell lung cancer (NSCLC)? ☐ Yes ☐ No
Positive for anaplastic lymphoma kinase (ALK)? ☐ Yes ☐ No

Prescription ☐ 600mg twice daily ☐ OTHER: _____

DISPENSE: _____-MONTH SUPPLY REFILL: _____ TIMES

ALECENSA SureStart® free starter supply ☐ 600mg twice daily

DISPENSE: 1-MONTH SUPPLY ☐ REFILL: 1 TIME

For COTELLIC® (cobimetinib) patients

Unresectable/metastatic melanoma? ☐ Yes ☐ No
Used in combination with ZELBORAF® (vemurafenib)? ☐ Yes ☐ No
(If yes, complete ZELBORAF section below.)

Prescription ☐ 60mg daily for 21 consecutive days on, followed by a 7-day rest period

☐ OTHER: _____

DISPENSE: _____-MONTH SUPPLY REFILL: _____ TIMES

Confirmed positive for BRAF V600E? ☐ Yes ☐ No
Confirmed positive for BRAF V600K? ☐ Yes ☐ No

For Tarceva® (erlotinib) patients

Treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations? ☐ Yes ☐ No

Advanced pancreatic cancer and have not received chemotherapy? ☐ Yes ☐ No

Prescription ☐ 150mg daily ☐ 100mg daily

☐ OTHER: _____ mg DAILY

DISPENSE: _____-MONTH SUPPLY REFILL: _____ TIMES

For ROZLYTREK™ (entrectinib) patients

Metastatic non-small cell lung cancer (NSCLC)? ☐ Yes ☐ No
Positive for ROS1? ☐ Yes ☐ No
Locally advanced or metastatic solid tumors? ☐ Yes ☐ No
Positive for neurotropic tropomyosoin receptor kinase (NTRK) fusions without a known acquired resistance? ☐ Yes ☐ No
Progression following prior therapy or Initial therapy when no satisfactory alternative therapy? ☐ Yes ☐ No

Lab test type?
☐ Next-Generation Sequencing (NGS) ☐ Polymerase chain reaction (PCR)
☐ Fluorescence in situ hybridization (FISH) ☐ Immunohistochemistry (IHC)

Prescription ☐ 600mg once daily ☐ OTHER: _____

DISPENSE: _____-MONTH SUPPLY REFILL: _____ TIMES

SureStart free starter supply ☐ 600mg once daily ☐ OTHER: _____

DISPENSE: 1-MONTH SUPPLY ☐ REFILL: 1 TIME

For ZELBORAF® (vemurafenib) patients

Unresectable/metastatic melanoma? ☐ Yes ☐ No ☐ Other
Confirmed positive for BRAF V600E? ☐ Yes ☐ No

Prescription ☐ 960mg twice daily ☐ OTHER: _____

DISPENSE: _____-MONTH SUPPLY REFILL: _____ TIMES

For Erivedge® (vismodegib) patients

Metastatic basal cell carcinoma? ☐ Yes ☐ No
Locally advanced basal cell carcinoma recurred following surgery, or not a candidate for surgery, and not a candidate for radiation? ☐ Yes ☐ No

Prescription ☐ 150mg daily ☐ OTHER: _____

DISPENSE: _____-MONTH SUPPLY REFILL: _____ TIMES

For XELODA® (capecitabine) patients

Attach prescription

Step 10 Prescriber Certification

By signing this form, I certify: (a) The above therapy is medically necessary for this patient and the treatment decision has been made by the prescribing physician. (b) If the indication for which you are prescribing a Genentech product is not listed in the FDA-approved label, you are prescribing the medication for an "unapproved" use, meaning that the FDA has not approved the efficacy, dosage amount or safety of this medication for such a use. (c) I received the authorization to release the information above and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc., Genentech Access Solutions, the contracted dispensing pharmacy, or other contractors for the purpose of requesting reimbursement support, assisting in initiating or continuing therapy, as a break in treatment would negatively impact the patient's therapeutic outcome and (d) I will not attempt to seek reimbursement for free product provided to the patient. I request Genentech Access Solutions convey to the pharmacy chosen by the above-named patient the prescription described herein. (e) The services you are requesting on behalf of the patient, may include benefits investigation (BI), benefits re-verification, prior authorization support (PA), co-pay card and co-pay assistance foundation referral. In the absence of a checkbox selecting a service, we will perform BI/PA services on behalf of the patient. **(f) No action on these services will be taken until the patient consent document has been received. (g) For prescribers in states with official prescription form requirements, such as New York, prescriptions must be submitted on an official state prescription pad along with this enrollment form.**

Sign, date & fax to **(877) 313-2659**

***Prescriber's Signature:** _____ ***Date:** ___/___/_____

(Original or stamped signature required)

Required field (*)

PATIENT CONSENT FORM

Genentech | ACCESS SOLUTIONS®
A Member of the Roche Group

Genentech-Access.com
Phone: (866) 422-2377 **Fax:** (866) 480-7762
6 a.m.–5 p.m. (PT) M-F

M-US-00002802(v1.0) 01/20

Instructions for Patients

By completing this form you can:

- Learn about your health insurance coverage and other options to get your Genentech medicine
- Enroll into optional disease-specific education, patient support services and communication

Please follow these 3 steps to get started:

1. Read "About Your Consent."
2. Sign and date page 3. Please note you must sign the form to get support for your treatment.
3. Send in your completed form using one of the options below.

Genentech can start supporting you when **page 3** of this form is submitted by you or your doctor's office in one of the following ways:

Complete online at
Genentech-Access.com/PatientConsent

OR

Take a photo and text it to
(650) 877-1111

OR

Print, complete and fax it to
(866) 480-7762

A representative from Genentech Access Solutions or your doctor's office will call you to tell you about your coverage, costs and support for your treatment.

If you have any questions, talk to your health care provider or contact Genentech Access Solutions.

Helpful Terminology

Genentech: The maker of the medicine your doctor wants to prescribe. Genentech is committed to helping patients get the medicine their doctor prescribed.

Genentech Access Solutions: A team at Genentech that works with your doctor and health insurance plan to help you get your medicine.

Genentech Patient Foundation: A program that gives free Genentech medicine to people who don't have insurance coverage or who have financial concerns and meet certain eligibility criteria.

Household size: Number of people living in your household, including you.

Household income: How much you and the members of your household currently make each year minus specific deductions. This is also frequently referred to as your Adjusted Gross Income or AGI. This information is needed to determine Genentech Patient Foundation eligibility.

Education and patient support services: Optional programs offered by Genentech to help you start and stay on your medicine. Services may vary based on your medical condition and could include co-pay assistance, clinical support, marketing communication and general disease information.

Deductible: The amount you pay for health care services or medicines out of pocket before your health insurance plan begins to pay.

Out-of-pocket costs: The amount not paid by the insurance plan that you must pay for your treatment. This includes deductibles, co-pays and co-insurance.

Co-pay assistance: Programs available to help eligible patients pay for their medicines.

Alternate contact: Someone you choose to be your contact person if Genentech Access Solutions cannot reach you.

If I receive free Genentech medicine from the Genentech Patient Foundation:

- I will not sell or give out this medicine since it is unlawful to do so. I am responsible to make sure these medicines are sent to a secure address when shipped to me, and I must control any Genentech medicine that I receive
- I understand that, for purposes of an audit, the Genentech Patient Foundation could ask me for a copy of my IRS 1040 form or other proof of income

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6 a.m.–5 p.m. (PT) M-F

About Your Consent – This relates to 'Box 1' on page 3

Your personally identifiable information (PII) may include:

- Name and birthdate
- Address, telephone number and email address
- Important financial information, as necessary
- Information on your medical condition, as necessary
- Information about your health benefits or health insurance coverage

Who may see and use my PII

I authorize Genentech and/or Genentech Patient Foundation to (i) use my PII for the purpose of facilitating my access to Genentech products and providing the services described below, and (ii) further disclose my PII to others who are assisting them in these services, and to my health care provider(s), health care entities, pharmacies, and health plan(s) for purposes of providing these services. Some of these disclosures may constitute a sale of PII. If so, I have the right to opt out of the sale of my PII if I reside in California. Additional information regarding my privacy rights can be found on Genentech's website privacy policy (www.gene.com/privacy-policy).

Reasons for sharing and using my information may include:

- Working with my health care plan to understand coverage for Genentech products
- Applying to the Genentech Patient Foundation
- Determining my eligibility and enrollment into financial assistance services, including co-pay assistance
- Coordinating my prescription through a pharmacy, infusion site and/or health care provider's office
- Providing treatment reminders and education

I direct and authorize my physician, pharmacy and my health plan(s) to disclose my PII to Genentech and its partners, as necessary for Genentech to provide the above services.

Once I sign this Patient Consent Form and my PII is transmitted to Genentech and/or Genentech Patient Foundation, I understand that the Health Insurance Portability and Accountability Act (HIPAA) may no longer protect or prohibit the redisclosure of the PII disclosed to Genentech and/or Genentech Patient Foundation by my health care provider or others covered by the HIPAA laws. I understand that Genentech and Genentech Patient Foundation are committed to protecting my information and keeping it secure and confidential while it is being collected or used to assist me and that the use and disclosure of my information will be limited to that described above. I can choose not to sign this form, but Genentech and Genentech Patient Foundation will not be able to assist me without it. However, my health care providers and health insurer may not condition either my treatment or my payment, enrollment or eligibility for benefits on signing this form.

The length and terms of this form

- This form is valid for 3 years from the date I signed or the date I last enrolled, whichever comes first, unless a shorter period is required by law
- I agree that if I reside in the state of Maryland, this form will be valid for no longer than 1 year from the date I signed
- I have the right to cancel this authorization. If I cancel, this means that Genentech and/or the Genentech Patient Foundation will no longer use or share my PII, but this will not apply to PII already used or shared or when it is required by law. If I reside in California, I also have the right to request that Genentech and/or the Genentech Patient Foundation delete my PII, although deletion is not required under certain circumstances. To cancel or request deletion, I must send a written notice to Genentech. It can be sent by fax or by mail to the address below. If I cancel and request deletion, I know that Genentech and the Genentech Patient Foundation will no longer be able to assist me with access to my Genentech products. The address is Genentech, 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990

I understand that I, as the patient or signer, have a right to receive a copy of this signed form over the time it is valid.

PATIENT CONSENT FORM

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M-US-00002802(v1.0) 01/20

Genentech-Access.com
Phone: (866) 422-2377 **Fax:** (866) 480-7762
6 a.m.–5 p.m. (PT) M-F

Required field (*)

Patient Information (to be completed by patient or their legally authorized person)

*First name: _____ *Last name: _____

Home phone†: ( ) - Cell phone†: ( ) -

☐ OK to leave a detailed message? ☐ OK to send a text message? Date of birth (MM/DD/YYYY) __/__/____

Email: _____ Preferred language: ☐English ☐Spanish ☐Other: _____

Alternate Contact (optional) Full name: _____

Relationship: _____ Phone†: ( ) -

1 Patient authorization via signature is required in order to obtain services from Genentech Access Solutions and the Genentech Patient Foundation. By signing this box, you agree to the terms in the 'About Your Consent' section.

REQUIRED

Sign and date here

_____ *Signature of Patient/Authorized Person (A parent or guardian must sign for patients under 18 years of age)

__/__/____ *Date signed (MM/DD/YYYY)

Person signing (if not patient)

_____ Print first name

_____ Print last name

_____ Relationship to patient

2 Financial Eligibility Information: Complete for Genentech Patient Foundation **only**

By completing this section, I am agreeing to the terms and conditions of the Genentech Patient Foundation outlined on page 1.

Household size (including you): _____ Annual household income:
☐Under $75,000 ☐$75,000 – $100,000 ☐$100,001 – $125,000 ☐$125,001 – $150,000 ☐Over $150,000

Sign and date here

_____ **Signature of Patient/Authorized Person** (A parent or guardian must sign for patients under 18 years of age)

__/__/____ **Date signed** (MM/DD/YYYY)

3 Patient consent to enroll in **optional** disease-specific education, support programs, market research and communication that may be considered marketing. I understand my PII may be needed for me to participate in these programs.

Sign and date here to choose to enroll

_____ **Signature of Patient/Authorized Person** (A parent or guardian must sign for patients under 18 years of age)

__/__/____ **Date signed** (MM/DD/YYYY)

†By providing my phone number and signing Box 3, I authorize Genentech to use auto-dialers or prerecorded and artificial voice to contact me. I understand that these calls/texts may mention the name of Genentech products or services, details about my insurance coverage and my doctor's name. I understand that I am not required to consent to being contacted by phone or text message as a condition of any purchase of Genentech products or enrollment. Message and data rates may apply. I understand that I may opt out of receiving these communications at any time by calling (877) GENENTECH (877-436-3683).

Once this page (3/3) has been completed, please text a photo of the page to **(650) 877-1111**, or fax to **(866) 480-7762**. You can also complete this form online at **Genentech-Access.com/PatientConsent**.