Genentech | Access Solutions
A Member of the Roche Group

Oncology

Prescriber Service Form

Complete online by scanning QR code

Required Field (*)

Submit Only Requested Documents

Save time by submitting this form online with Quick Enroll

NO ACCOUNT REQUIRED

Questions? Call Oncology Access Solutions at (888) 249-4918

Step 1 Services Requested
(Check all that apply)

☐ **Benefits Investigation/Prior Authorization** ☐ **Co-pay Referrals** ☐ **Appeals Support**

Step 2 Patient Information

***First Name:** _____ ***Last Name:** _____ ***DOB (MM/DD/YYYY):** ____/____/____

Street: _____ Apt: _____ Gender: ☐ Male ☐ Female

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 3 Insurance Information

Is the patient insured? ☐ Yes ☐ No Is PA in place? ☐ Yes ☐ No Auth #: _____

If patient is uninsured or without any form of health insurance please complete the Prescriber Foundation Form here Quick Enroll or call (888) 941-3331 for assistance. If insured, please fill out the information below or attach a copy of the patient's health insurance cards.

	Primary Insurance	Secondary Insurance	PBM/RX Insurance (Needed for Orals)
Insurance Name			
Subscriber Name (if not patient)			
Subscriber ID			
Policy/Group #			
Insurance Phone #			

Step 4 Diagnosis and Clinical Information

Please complete all fields that apply to your patient to prevent enrollment delays

ICD-10 codes should be highest level of specificity:

***Primary ICD-10 Code:** _____.____

Secondary ICD-10 Code: _____.____

Has the patient started therapy? ☐ Y ☐ N

First Treatment Date: ____/____/____

***Line of Therapy:** ☐ 1L ☐ 2L ☐ 3L or later

Biomarker Status (Select all that apply)

☐ *PIK3CA*+

HER2 Status:

☐ HER2+ ☐ HER2-

Hormone Receptor (HR) Status:

☐ HR+

☐ ALK+

☐ PD-L1+

☐ ROS1+

☐ NTRK Fusion+

☐ Other:_____

Disease Stage

☐ Stage 0-3

☐ Metastatic

Treatment Setting

☐ Neo-adjuvant

☐ Adjuvant Therapy

Step 5 Oncology Co-Pay Program Enrollment for Patients with Commercial Insurance ONLY

☐ **By checking this box, I certify:** I have the patient's consent to enroll in the Genentech Oncology Co-Pay Program for assistance with drug out-of-pocket costs and / or Genentech Oncology administration out-of-pocket costs. The patient is not using and you will not bill any federal or state-funded health care program. This includes, but is not limited to, Medicare, Medicaid, Medigap, VA, DoD and TRICARE. The patient is not currently receiving Genentech Oncology drugs from the Genentech Patient Foundation. The patient is not currently receiving assistance from any other charitable organization for any of their out-of-pocket costs that are covered by the Genentech Oncology Co-pay Program. Genentech reserves the right to rescind, revoke or amend the program without notice at any time.
I have read and accepted the full Program Terms and Conditions as found on the following link: go.gene.com/oncology

Genentech Medicines & FDA Approved Indications List: https://www.gene.com/medical-professionals/medicines

Please **continue to Step 6** on the next page

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Step 6 Patient Information (please re-enter)

*First Name: _____ *Last Name: _____ *DOB (MM/DD/YYYY): ____/____/____

Step 7 Patient Cancer Medicine(s)

Genentech Oncology Medicine List: genentech-access.com/hcp/oncology

*Genentech Oncology Medicines Brand name only	*Formulation Type Please indicate infused (IV), oral, subcutaneous (SC) or other	ORALS ONLY: REQUIRED PRESCRIPTION INFORMATION			
		Size/Strength	Quantity	Frequency/Directions For weight-based medications, please include exact dose or patient weight	Refills

Clinical trial participant for this medicine? ☐ Yes

☐ Combination Therapy Benefits Investigation Combination Therapy Regimen Name: _____

OR list cancer therapies prescribed in combination with Genentech medicine(s) OR attach medication list: _____

_____

Where will medicines be administered? ☐ Physician's office ☐ HOPD ☐ Other (please specify): _____

Name: _____ Tax ID #: _____ NPI #: _____

Medication(s) dispensed through: ☐ Buy and bill ☐ Onsite pharmacy ☐ Specialty pharmacy (SP): _____

Step 8 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: (_____) _____-_____

If you are a resident of a US state that provides certain rights with respect to your personal information, a complete description of the personal information we may collect and process, the purposes for which it is used by Genentech, and your rights under your state's privacy laws concerning your personal information can be found in our privacy notice at https://www.gene.com/privacy-policy.

Step 9 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), prior authorization (PA) and appeals support, co-pay program referral or enrollment and co-pay assistance foundation referral. (f) No action on these services will be taken until the patient consent document has been received.

Step 10 ORALS ONLY Prescriber's Signature Required

By signing this form, I certify: (a) - (f) in Step 9 and: **(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)

PATIENT CONSENT FORM

Genentech
A Member of the Roche Group | Access Solutions

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

M-US-00002802(v3.0)

Instructions for Patients

By completing this form, you can:

- Learn about your health insurance coverage and other options to get your Genentech medicine
- Sign up to receive optional disease education and other material

Please follow these 3 steps to get started:

1. Read "Authorization to Use and Disclose Personal Information" on pages 2 and 3.
2. Sign and date page 4. 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 4** of this form is submitted by you or your doctor's office in one of the following ways:

Complete online by scanning this QR code or visiting **Genentech-Access.com/PatientConsent**

OR

Print, complete, take a photo and text it to **(650) 877-1111**

OR

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

If you have any questions, talk to your health care provider or call Genentech Access Solutions at (866) 422-2377.

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. When used on this form, the term "Genentech" refers to Genentech, Genentech Patient Foundation, and their respective partners, affiliates, subcontractors and agents.

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 health insurance coverage or who have financial concerns and meet certain eligibility criteria.

Net 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.

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

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 health insurance plan that you must pay for your treatment. This includes premiums, 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. An Alternate Contact may not be an individual associated with or a representative of your insurance company, employer, or a business partner of your insurance company or employer.

Legally authorized representative: An individual or judicial or other body authorized under applicable law to consent on behalf of a patient (e.g., parent or legal guardian of a minor).

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Terms and Conditions of the Genentech Patient Foundation

- If I receive free medicine from the Genentech Patient Foundation, I will not sell or give out the medicine because it is illegal to do so. I am responsible to ensure that the medicine is sent to a secure address when shipped to me, and I must control any medicine that I receive
- I understand that, for purposes of an audit, the Genentech Patient Foundation may ask me for a copy of my IRS 1040 form or other proof of income
- Some insurance plans and/or employers partner with organizations known as alternate funding programs. Such arrangements require patients to apply to the Genentech Patient Foundation as a condition of, or prerequisite to, coverage of relevant Genentech products. These alternate funding programs include SHARx, Paydhealth, and Payer Matrix, among others. Patients whose insurance plans and/or employers use an alternative funding program are ineligible for support from the Genentech Patient Foundation
- I acknowledge that, to the best of my knowledge, neither my insurance plan nor my employer (1) required me to apply to the Genentech Patient Foundation and/or (2) changed or hid my insurance coverage for my Genentech medicine to make me appear to be underinsured and eligible for support from the Genentech Patient Foundation. I am not applying to the Genentech Patient Foundation on behalf of someone whose insurance plan and/or employer partners with an alternative funding program. The Alternate Contact listed on my application (if any) is not associated with or a representative of my insurance company, employer, or a business partner of my insurance company or employer. If I subsequently learn that my insurance plan and/or employer uses an alternative funding program, I agree to inform the Genentech Patient Foundation immediately and understand that I will no longer be eligible for support

Authorization to Use and Disclose Personal Information

I authorize my physician(s) and their staff, pharmacies, and health insurance plan (my "health care providers") to share my personal information, which may include contact information, demographic information, financial information, and information related to my medical condition, treatments, and health insurance and benefits, with Genentech, Genentech Patient Foundation, and their respective partners, affiliates, subcontractors, and agents (together, "Genentech"). I authorize Genentech to receive, use, and share my personal information in order to provide me with access to the products, services, and programs described on this form, which may include the following:

- Working with my health insurance plan to understand or verify coverage for Genentech products
- Applying to the Genentech Patient Foundation
- Determining my eligibility for and facilitating enrollment into financial assistance services if I'm eligible, including co-pay assistance
- Coordinating my prescription through a pharmacy, infusion site and/or health care provider's office. This includes contacting me to discuss my coverage, costs and eligibility for assistance and other program administration purposes
- Facilitating my access to Genentech products
- Ensuring quality and safety and improving our products and services

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Authorization to Use and Disclose Personal Information (cont)

- Contacting me by mail, e-mail, telephone calls and text messages at the number(s) and address(es) provided for non-marketing purposes
- If I agree to the **optional** Consent for Patient Resources and Information, providing me with **optional** disease information and marketing material about products, services and programs offered by Genentech, its partners and their respective affiliates. This is not required to enroll into Genentech Access Solutions services
- If I agree to the **optional** Telephone Consumer Protection Act (TCPA) Consent, contacting me by autodialed calls and/or text messages at the phone number(s) I have provided for marketing purposes. This is not required to enroll into Genentech Access Solutions services

I understand that this will include sharing and use of information about me that could be considered sensitive personal information, such as health conditions, but that the use of this information by Genentech is necessary to determine if I qualify for and to administer the benefits and services for which I am applying. I understand that Genentech may also share my personal information, including sensitive personal information, for the purposes described on this authorization with my health care providers, service providers, and any individual I may designate as an alternate contact. I understand that my pharmacy may receive payment or other remuneration for disclosing my personal information pursuant to this authorization. I can choose not to sign this authorization, but Genentech will not be able to provide the services to me without it. However, my health care providers may not condition either my treatment or my payment, enrollment, or eligibility for benefits on signing this authorization.

I also understand and agree that:

- This authorization is valid for 6 years from the date I sign or the date I last enrolled, whichever comes first, unless a shorter period is required by law, or I revoke it earlier
- My personal information released under this authorization may no longer be protected by state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA). However, Genentech will only use and share my personal information for the purposes stated on this authorization or as otherwise permitted by law
- I have the right to revoke (cancel) this authorization at any time by submitting a written notice to: Genentech Access Solutions, 1 DNA Way, South San Francisco, CA 94080-4990 or by calling **(866) 422-2377**. If I revoke this authorization, I will no longer be eligible for the services described. If a health care provider is disclosing my personal information to Genentech on an authorized, ongoing basis, my revocation will be effective with respect to such health care provider when they receive notice of my revocation. My revocation will not impact uses and disclosures of my personal information that have already occurred in reliance on this authorization
- More information on my privacy rights, including specific rights I may have as a resident of certain states, can be found in Genentech's privacy policy (**www.gene.com/privacy-policy**)
- I have a right to receive a copy of this authorization

PATIENT CONSENT FORM

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Required field (*)

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

*First name: _____ *Last name: _____

Home phone: ( ) - _____ Cell phone: ( ) - _____

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

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

Alternate Contact (optional) Full name: _____

Relationship: _____ Phone: ( ) - _____

1 Financial Eligibility: Complete **only** if you are applying to the Genentech Patient Foundation

By completing this section, I am agreeing to the Terms and Conditions of the Genentech Patient Foundation outlined on page 2.

Household size (including you): _____

Annual household income: _____

2 Consent for Patient Resources and Information (**OPTIONAL**)

Genentech offers **optional** and free disease education and other material for patients. This may include information and marketing material about products, services and programs offered by Genentech, its partners and their respective affiliates. If you sign up, you may be contacted using the information you have provided.

☐ By checking this box, I agree to receive **optional** disease education and other material. I understand providing this agreement is voluntary and plays no role in getting Genentech Access Solutions services or my medicine and that it may be necessary to use my sensitive personal information to provide me with relevant material. I also understand that I may opt out of receiving this information at any time by calling **(877) 436-3683** and that this consent will remain active unless I opt out.

Telephone Consumer Protection Act (TCPA) Consent (**OPTIONAL**)

☐ By checking this box, I consent to receive autodialed marketing calls and text messages from and on behalf of Genentech at the phone number(s) I have provided. I understand that consent is not a requirement of any purchase or enrollment. Message frequency may vary. Message and data rates may apply. I may opt out at any time by texting STOP or calling **(877) GENENTECH**/(877) 436-3683.

3 REQUIRED

By signing this form, I acknowledge that I have provided accurate and complete information and understand and agree to the terms of this form. My signature certifies that I have read, understood, and agree to the release and use of my personal information, including sensitive personal information, pursuant to the Authorization to Use and Disclose Personal Information and as otherwise stated on this form.

Sign and date here

_____ __/__/____

*Signature of Patient/Legally Authorized Representative (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

Once this page (4/4) 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**.

If this is an electronic consent, you understand that by typing your name and the date above and submitting, or taking a picture and sending to us, that you are providing your consent electronically and that it has the same force and effect as if you were signing in person on paper. Genentech reserves the right to rescind, revoke or amend the program without notice at any time.