

ENROLLING PATIENTS

in MySMA Support™
by Genentech



MySMA Support is a support service from Genentech that can help provide information about Evrysdi® (risdiplam).

- The MySMA Support team can help you understand your patient's insurance coverage and refer your patients to appropriate financial assistance options to help them start and stay on Evrysdi
- MySMA Support does not provide medical advice and is not a substitute for the medical team. Health care providers should always be the main resource for any questions about patients' health and medical care


To enroll in MySMA Support, patients and providers simply need to complete the Evrysdi Start Form. Look inside for tips on completing the form.

Instructions, Consent Information and Patient Consent Form
Pages 1-4

Instructions and Prescriber Service Form
Pages 5-6

To learn more:

 Visit [Evrysdi.com](https://www.evrysdi.com)

 Call MySMA Support at **(833) 387-9734**
Monday through Friday, 9 a.m.—8 p.m. ET

Genentech
A Member of the Roche Group



FOR HEALTH CARE PROVIDERS

Tips for Completing the Evrysdi Start Form: Patient/Caregiver Considerations



Page 4 of the Evrysdi Start Form (the blue colored “Patient Consent Form”) should be filled out by the patient or caregiver.

- **Be sure to carefully review Pages 1-3 of the Evrysdi Start Form with the patient or caregiver** before he or she completes **Page 4** to ensure complete understanding of the MySMA Support™ offerings
- Areas highlighted in **red** indicate required information. Please note that complete contact information, including an active email address, can expedite the approval process and help ensure patients quickly receive the full range of support and resources
- **This form also can be filled out online at [Evrysdi.com/Forms](https://www.evrysdi.com/Forms)**



Patient Information

Providing patient contact information and an alternate contact, including an active email address, can help us work with the patient most effectively.



Section 1

Needed to determine if the patient may be eligible for free Evrysdi® (risdiplam) from the Genentech Patient Foundation. The household size and income is used **ONLY** to determine eligibility.

Note: Prescribers must complete the Prescriber Foundation Form (available at [GenentechPatientFoundation.com](https://www.GenentechPatientFoundation.com)) to complete enrollment.



Section 2

Complete this section if the patient would like to receive disease education materials and product support, including items or marketing materials explaining the product and how to take it, use when traveling and other information about Genentech products, services and programs



Section 3

Signature and date required for the patient to receive assistance from MySMA Support and the Genentech Patient Foundation.

GENENTECH PATIENT SUPPORT SERVICES **Evrysdi® Start Form**
www.evrysdi.com/forms Phone: (833) 387-9734 Fax: (833) 387-9700
*Required field M-US-00001154(v7.0)

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: _____ Phone: (____) _____-____
Relationship: _____

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 disease education and product support for patients, including items or marketing materials explaining the product and how to take it, use when traveling with the product and other information about Genentech products, services and programs. You do not have to sign up for these resources and support to get help with your insurance coverage or to learn about financial assistance options. Signing up here allows you to be contacted using the information you provide on this form. These marketing materials and support are optional, free and may be provided by a PAL, Genentech's partners and their respective affiliates. PALs do not provide medical advice. Your healthcare provider should always be your main resource for any questions about your health and medical care.
☐ By checking this box, I agree to receive disease education materials and product support services, including outreach by a PAL. I understand that I don't have to opt into this offer and my decision does not affect receiving my medicine or financial support information. 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.
☐ By checking this box, I agree to receive autodialed calls and text messages, which may include marketing communications about Evrysdi from and on behalf of Genentech, including from a PAL, at the phone number(s) provided. I understand that choosing to receive these messages is voluntary and is not a requirement of any purchase or program 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. I am also agreeing to the Privacy Policy (www.gene.com/privacy-policy) and SMS Terms & Conditions (www.gene.com/terms-conditions/sms-text-message-program-terms-conditions).

3 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.

REQUIRED Sign and date here _____ *Signature of Patient/Legally Authorized Representative _____ *Date signed (MM/DD/YYYY) _____
(A parent or guardian must sign for patients under 18 years of age)
Person signing (if not patient) _____
Print first name _____ Print last name _____ Relationship to patient _____

Once this page (4/6) has been completed, please text a photo of the page to (650) 877-1111 or fax to (833) 387-9700. You can also complete this form online at www.evrysdi.com/forms.
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.
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Note: Patients must provide both a signature and date in Section 3.

Submit Page 4 by:

✎ **Completing it online using the QR code or visiting [Evrysdi.com/Forms](https://www.evrysdi.com/Forms)**



📱 **Texting a photo of the completed form to (650) 877-1111**



📠 **Faxing to (833) 387-9700**

Tips for Completing the Evrysdi Start Form: Health Care Provider Considerations



Page 6 of the Evrysdi Start Form (the green colored “Prescriber Service Form”) should be filled out by the provider for all patient support requests.

- Areas highlighted in **red** indicate required information. Please note that completing the entire form can expedite the approval process and help ensure patients quickly receive the full range of support and resources
- This form also can be filled out online at [Evrysdi.com/Forms](https://www.evrysdi.com/Forms)



Step 2: Insurance Information

You may complete the insurance information in Step 2 or attach a copy of the patient’s medical and prescription insurance cards.



Step 3: Diagnosis and Clinical Information

To expedite processing and delivery, be sure to complete Step 3 in its entirety:

- Include the appropriate diagnosis code and copy number or type
- Please remember to select lb or kg for the patient’s weight
- If the patient has been on a previous therapy, please select the therapy and include the date of the last dose



Step 6: Evrysdi Start Program

With the Evrysdi Start Program, eligible patients may receive free medicine while awaiting an insurance coverage determination. Be sure to complete Step 6 and fill out the dispensing information to enroll your patient.



Signature

Be sure to check the signature authorization boxes on Steps 4 and 6 and provide an original signature on Step 7 for the specialty pharmacy to dispense needed ancillary supplies for enteral administration of Evrysdi. MySMA Support will forward the Start Form to the specialty pharmacy for processing.

The Generic Substitution line is provided to qualify the form as a valid prescription in certain states to determine eligibility. Note that there is no generic version of Evrysdi.

GENENTECH PATIENT SUPPORT SERVICES **Evrysdi® Start Form**
 www.evrysdi.com/forms Phone: (833) 387-9734 Fax: (833) 387-9700
 risdiplam
 *Required field M-US-00001154(v7.0)

Prescriber Service Form (to be completed by the prescriber)

Step 1 Patient Information

*First name: _____ *Last name: _____ Gender: ☐ Male ☐ Female
 *Date of birth (MM/DD/YYYY): ____/____/____ Preferred language: ☐ English ☐ Spanish ☐ Other: _____
 Street: _____ Apt: _____ City: _____ *State: _____ ZIP: _____
 Home phone: (____) _____ Cell phone: (____) _____ Alt. phone: (____) _____
 Alternate contact name: _____ Relationship: _____ Do not contact patient ☐

Step 2 Insurance Information

Is the patient insured? ☐ Yes ☐ No If patient is uninsured, please refer to the Genentech Patient Foundation.
 If insured, please fill out the information below or attach a copy of the patient’s medical and prescription insurance cards.

Primary Insurance	Secondary Insurance	Pharmacy Benefit
Insurance name		
Subscriber name (if not patient)		
Subscriber/Policy ID #		
Group #		
Insurance phone		

☐ Patient is currently pursuing coverage for their medicine, and currently experiencing a gap in therapy.
 Current gap in coverage: ☐ Pending prior authorization ☐ Pending appeal ☐ Pending establishment of coverage

Step 3 Evrysdi Start Program (Signature Required)

Dispense: 1-shipment supply ☐ _____ mg (____ mL) once daily OR ☐ 5 mg (6.6 mL) once daily
☐ 1-time refill. Weight-based dosing will require a new Rx.
☐ Your signature authorizes the specialty pharmacy to dispense needed ancillary supplies for enteral administration of this medication, such as: ENFit® adapters, oral syringes, cassettes, administration sets and tubing.

Step 4 Diagnosis and Clinical Information

*Diagnosis code(s): ☐ G12.0 Infantile spinal muscular atrophy, type I ☐ G12.1 Other inherited spinal muscular atrophy
☐ G12.9 Spinal muscular atrophy, unspecified ☐ Other: _____
 SMA type: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 SMN2 copy number: _____ Patient weight: _____ lbs ☐ kgs Date measured: ____/____/____
 Has patient taken Evrysdi? ☐ Yes ☐ No Expected Evrysdi treatment start date: ____/____/____
 Previous therapy: ☐ Spinraza® (nusinersen) last dose: ____/____/____ ☐ Zolgensma® (onasemnogene asepavovect-xtol) last dose: ____/____/____
 Other: _____ last dose: ____/____/____ ☐ Drug and non-drug allergies: _____ ☐ No known allergies

Step 5 Prescription Information

Strength: Evrysdi® (risdiplam) 0.75 mg/mL, 80 mL (in 100-mL bottle) _____ mg (____ mL) once daily ☐ 5 mg (6.6 mL) once daily
 Directions: _____ SIG: _____ Route: ☐ Oral ☐ Feeding tube
 Quantity: ☐ 1-month supply ☐ Other: _____ Refills: _____

Step 6 Prescriber Information

*First name: _____ *Last name: _____ *Practice name: _____
 *Street: _____ Suite: _____ *City: _____ *State: _____ *ZIP: _____
 Prescriber fax ID #: _____ Prescriber NPI #: _____ Group NPI #: _____
 Office contact: _____ Contact phone: (____) _____ 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 www.gene.com/privacy-policy.

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 I am prescribing a Genentech product is not listed in the FDA-approved label, I am 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 obtaining or continuing therapy, as a break in treatment would negatively impact the patient’s therapeutic outcome and (d) My patient meets the criteria for the Genentech Patient Foundation and to the best of my knowledge, this patient has no prescription insurance coverage (including Medicaid, Medicare, or other public or private programs) for the Genentech medicine listed above, or is unable to afford the cost-sharing requirements associated with his/her insurance coverage for this medication. If the patient is enrolled in an insurance plan, the plan does not require the patient’s application to the Genentech Patient Foundation and/or has not changed or hidden the patient’s coverage for the Genentech medicine to make them appear to be uninsured and eligible for the Genentech Patient Foundation. (e) The services you are requesting on behalf of the patient, may include benefits investigation (BI), prior authorization support (PA), co-pay card and co-pay assistance foundation referral. (f) No action on these services will be taken until the patient consent document has been received. (g) Prescribers must comply with all state-specific prescription requirements, such as e-prescribing, state-specific prescription form, language, etc. Noncompliance with state-specific requirements could result in a breach to the prescriber. (h) My patient meets the criteria for Genentech Patient Foundation (GPF). (i) I understand that Genentech reserves the right to modify or discontinue the program at any time and to verify the accuracy of information submitted. (j) I understand that the GPF does not provide free drug in the instance of an administrative error or a coverage restriction, such as a stop sale. For certain products where the stop sale may not be medically appropriate, as confirmed by the prescribing physician, the GPF may consider support following a 1-year of appeal.

☐ Sign, date & fax to (833) 387-9700 (Original signature required) / OR / ☐ Date (Prescriber Signature – Dispense as Written) (Original signature required)
☐ Date (Prescriber Signature – Generic Substitution Permitted) (Original signature required)

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Submit Page 6 by: Completing it online at [Evrysdi.com/Forms](https://www.evrysdi.com/Forms) OR Faxing to (833) 387-9700

THE MySMA SUPPORT™ TEAM

Provides You and Your Patients
the Information You Need



Partnership and Access Liaison (PAL): The local, main point of contact from Genentech who supports your patients.

- PALs are not part of your medical team and do not provide medical advice. A PAL will always direct patients to their health care providers for any questions about the patient's health and/or medical care



Neurological Rare Disease Account Managers (NRD AMs): The local, dedicated support resource for practices who answers questions about Genentech's approved products and services. This can include answering:

- Evrysdi® (risdiplam) clinical questions
- General reimbursement and insurance questions
- Evrysdi Start Form questions
- Evrysdi Bridge Program questions



Case Manager (CM): Partners closely with you and other members of the MySMA Support team to help your patients understand the health insurance process and identify potential financial support options for Genentech's approved products.



Specialty pharmacy (SP): A specialty pharmacy prepares and ships Evrysdi directly to patients each month. Although the SP is not a part of Genentech, it is an important part of the MySMA Support Team.*

*Specialty pharmacies are not part of Genentech and maintain independence in their operations and in their role as a health care provider.

To learn more:

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