

**Step 1 Patient Information**

Services Requested (Check all that apply):  
 Benefits Investigation/ Prior Authorization  
 Refer Patient to Co-pay Assistance  
 Appeals Support

**\*First name:** \_\_\_\_\_ **\*Last name:** \_\_\_\_\_  
**\*Date of birth (MM/DD/YYYY):** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender:  Male  Female  
 Street: \_\_\_\_\_ Apt: \_\_\_\_\_  
 City: \_\_\_\_\_ **\*State:** \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Home phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Do not contact patient  
 Email: \_\_\_\_\_ Preferred language:  English  Spanish  Other: \_\_\_\_\_

**Step 2 Insurance Information**

Is the patient insured?  Yes  No

 **If patient is uninsured, please complete the Genentech Patient Foundation Enrollment Form or call (888) 941-3331 for assistance.**  
**If insured, please fill out the information below or attach a copy of the patient's insurance cards.**  
 Is prior authorization in place?  Yes  No Auth #: \_\_\_\_\_

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

**Step 3 Diagnosis and Clinical Information**

**To the highest level of specificity, provide:**  
**\*Primary diagnosis code:** \_\_\_\_\_ **Has patient started therapy?**  Yes  No  
 Secondary diagnosis code: \_\_\_\_\_ **\*Metastatic basal cell carcinoma?**  Yes  No  
**Erivedge® (vismodegib) capsule 150 mg** **\*Locally advanced basal cell carcinoma recurred following surgery, or not a candidate for surgery, and not a candidate for radiation?**  Yes  No  
 150 mg daily  Other: \_\_\_\_\_ Dispense: \_\_\_\_\_ -month supply Refill \_\_\_\_\_ times


**Pharmacy and Shipping Information:**  
 Specialty pharmacy:  Yes  No Preferred specialty pharmacy: \_\_\_\_\_  
 Onsite pharmacy:  Yes  No Onsite pharmacy: \_\_\_\_\_  
 Ship to:  Patient  Practice  Other: \_\_\_\_\_

**Step 4 Prescriber Information**

**\*First name:** \_\_\_\_\_ **\*Last name:** \_\_\_\_\_  
**\*Practice name:** \_\_\_\_\_  
**\*Street:** \_\_\_\_\_ Suite: \_\_\_\_\_ **\*City:** \_\_\_\_\_  
**\*State:** \_\_\_\_\_ **\*ZIP:** \_\_\_\_\_ Prescriber tax ID #: \_\_\_\_\_  
 Prescriber NPI<sup>†</sup> #: \_\_\_\_\_ Group NPI<sup>†</sup> #: \_\_\_\_\_  
 Office contact: \_\_\_\_\_ Contact phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Contact fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Step 5 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 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.**

 Sign, date & fax to (877) 313-2659 **\*Prescriber's Signature:** \_\_\_\_\_ **\*Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 (Original or stamped signature required)

<sup>†</sup> National Provider Identifier.  
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