Genentech | ACCESS SOLUTIONS
A Member of the Roche Group

for Erivedge®
(vismodegib) capsule

Prescriber Service Form

SUBMIT ONLY REQUESTED DOCUMENTS

Required field (*) **M-US-00006688(v1.0)** **08/20**

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:** _____

Secondary diagnosis code: _____

Has patient started therapy? ☐ Yes ☐ No

***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**

Erivedge® (vismodegib) capsule 150 mg

☐ 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† #: _____ Group NPI† #: _____

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)

† National Provider Identifier.