Genentech | Access Solutions
A Member of the Roche Group

for HEMLIBRA®
(emicizumab-kxwh)

Prescriber Service Form

SUBMIT ONLY REQUESTED DOCUMENTS

Complete online by scanning QR code or visit **Quick Enroll (QE)**

Required field (*) **M-US-00006693(v3.0)**

Step 1 Patient Information

***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: _____

Alternate contact name: _____ Relationship: _____ Alt. phone: (___) ___-_____

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.

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

Step 3 Prescription Information

Patient weight: _____

		Please specify quantity of each applicable vial	Directions	Refills
Initial dose	☐ 3 mg/kg, _____ mg/kg	____ 12 mg/0.4 mL, ____ 30 mg/mL, ____ 60 mg/0.4 mL, ____ 105 mg/0.7 mL, ____ 150 mg/mL, ____ 300 mg/2 mL		
Subsequent dose	☐ 1.5 mg/kg ☐ 3 mg/kg ☐ 6 mg/kg, _____ mg/kg	____ 12 mg/0.4 mL, ____ 30 mg/mL, ____ 60 mg/0.4 mL, ____ 105 mg/0.7 mL, ____ 150 mg/mL, ____ 300 mg/2 mL		

Preferred specialty pharmacy: _____ **Onsite pharmacy:** _____

Step 4 Diagnosis and Clinical Information (*Complete to the highest level of specificity for diagnosis codes.)

***Primary diagnosis code:** _____ Does your patient have Hemophilia A ☐ With inhibitors? or ☐ Without inhibitors?

Has the patient started prescribed HEMLIBRA® (emicizumab-kxwh)? ☐ Yes ☐ No

Has it been 12 months or more since the patient's last HEMLIBRA injection? ☐ Yes ☐ No

Step 5 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: (___) ___-_____

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 6 HEMLIBRA Co-pay Assistance Program Enrollment

☐ By checking this box, I certify that:

- I have the patient's consent to enroll in the Genentech HEMLIBRA Co-pay Assistance Program for assistance with drug out-of-pocket costs and/or Genentech HEMLIBRA administration out-of-pocket costs
- The patient is not using and I 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 HEMLIBRA 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 HEMLIBRA Co-pay Assistance 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: **www.hemlibracopay.com/terms-and-conditions**

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), 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.

Sign, date & fax to **(877) 886-5629**

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

(Original or stamped signature required)

DoD=US Department of Defense; FDA=US Food and Drug Administration; NPI=National Provider Identifier; VA=Veterans Affairs.