Genentech | ACCESS SOLUTIONS®
A Member of the Roche Group

for HEMLIBRA®
(emicizumab-kxwh)

Prescriber Service Form

SUBMIT ONLY REQUESTED DOCUMENTS

Required field (*) **M-US-00006693(v1.0)** **08/20**

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	_____ 30-mg/mL, _____ 60-mg/0.4-mL, _____ 105-mg/0.7-mL, _____ 150-mg/mL		
Subsequent dose	☐ 1.5-mg/kg, ☐ 3-mg/kg, ☐ 6-mg/kg, _____ mg/kg	_____ 30-mg/mL, _____ 60-mg/0.4-mL, _____ 105-mg/0.7-mL, _____ 150-mg/mL		

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

Step 4 Diagnosis and Clinical Information

***To the highest level of specificity, provide 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: (_____) _____-_____

Step 6 HEMLIBRA Starter Request (signature required)

☐ I approve the dispensing of up to 2 free 30-day supplies of HEMLIBRA to my patient if they experience an insurance coverage delay and otherwise meet eligibility criteria. For full eligibility criteria, please speak to your HEMLIBRA representative.

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 card 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)

†National Provider Identifier.