Genentech | ACCESS SOLUTIONS®
A Member of the Roche Group

Prescriber Service Form

SUBMIT ONLY REQUESTED DOCUMENTS

Required field (*)

Step 1 Patient Information

SERVICES REQUESTED
(check all that apply):

- ☐ **Benefits Investigation (BI) and Prior Authorization (PA) Support**
  - ☐ Re-verify benefits at PA expiration
- ☐ **Co-pay Referrals**
  - – Genentech Co-pay Card
  - – Co-pay Assistance Foundation
- ☐ **Appeals Support**

If you believe your patient is eligible for free medicine, call Genentech Patient Foundation at (888) 941-3331.

***FIRST NAME:** _____ ***LAST NAME:** _____

***DATE OF BIRTH (MM/DD/YYYY):** ____/____/____ ***GENDER:** ☐ MALE ☐ FEMALE

***STREET:** _____ APT: _____

***CITY:** _____ ***STATE:** _____ ***ZIP:** _____

PHONE: (____) ____-____ PHONE TYPE: ☐ CELL ☐ HOME

☐ DO NOT CONTACT PATIENT EMAIL: _____

PATIENT-PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER: _____

ALTERNATE CONTACT NAME: _____

RELATIONSHIP: _____ ALT PHONE: (____) ____-____

Step 2 Insurance Information

Please fill out the information below or attach insurance cards.

☐ **See copy of insurance cards**

Is the patient insured? ☐ Yes ☐ No

Is PA in place? ☐ Yes ☐ No AUTH#: _____

	PRIMARY INSURANCE	SECONDARY INSURANCE	PHARMACY BENEFIT
INSURANCE NAME			
SUBSCRIBER NAME (if not patient)			
SUBSCRIBER ID			
POLICY/GROUP #			
INSURANCE PHONE #			

Step 3 Patient's Therapy (check all that apply)

Infused and Subcutaneous (SC) Therapy

- ☐ Avastin® (bevacizumab)
- ☐ GAZYVA® (obinutuzumab)
- ☐ Herceptin® (trastuzumab)
- ☐ Herceptin HYLECTA™ (trastuzumab and hyaluronidase-oysk)
- ☐ KADCYLA® (ado-trastuzumab emtansine)
- ☐ PERJETA® (pertuzumab)
- ☐ PHESGO™ (pertuzumab/trastuzumab/hyaluronidase-zzxf)
- ☐ POLIVY™ (polatuzumab vedotin-piiq)
- ☐ RITUXAN® (rituximab)
- ☐ RITUXAN HYCELA® (rituximab/hyaluronidase human)
- ☐ TECENTRIQ® (atezolizumab)

Oral Therapy (complete prescription on page 3)

- ☐ ALECENSA® (alectinib)
- ☐ COTELLIC® (cobimetinib)
- ☐ Erivedge® (vismodegib)
- ☐ ROZLYTREK® (entrectinib)
- ☐ XELODA® (capecitabine) **For XELODA requests, attach prescription**
- ☐ ZELBORAF® (vemurafenib)

List medications used in combination with Genentech therapy for a regimen benefits investigation.

☐ **See attached medication list**

REGIMEN NAME: _____

MEDICATIONS/DOSING OR BILLING CODES: _____

Where will infused or SC medication(s) be provided?

☐ Physician's office ☐ Hospital outpatient department ☐ Other (please specify)*

NAME: _____

TAX ID#: _____ NPI† ID #: _____

Oral therapy dispensed through:

☐ Onsite pharmacy ☐ Specialty pharmacy (SP)

PREFERRED SP: _____

Please **continue to Step 4** on the next page

†National Provider Identifier.

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Step 4 Patient Information (please re-enter)

***FIRST NAME:** _____ ***LAST NAME:** _____ ***DOB (MM/DD/YYYY):** ____/____/____

Step 5 Diagnosis and Clinical Information

To the highest level of specificity, provide:

***PRIMARY DIAGNOSIS CODE:** _____

SECONDARY DIAGNOSIS CODE: _____

Has the patient started therapy? ☐ Yes ☐ No Date of Treatment: ____/____/____

Line of therapy: ☐ First ☐ Second ☐ Other _____

HER2 positive? ☐ Yes ☐ No

PD-L1 positive? ☐ Yes ☐ No

Neo-adjuvant: ☐ Yes ☐ No

Adjuvant: ☐ Yes ☐ No

Clinical TNM stage:

☐ 0 ☐ IIA ☐ IIIA ☐ IIIC

☐ 1 ☐ IIB ☐ IIIB ☐ IV

Previous treatment:

☐ None ☐ Radiation ☐ Hormone therapy ☐ Surgery

☐ Other (if chemotherapy, please specify) _____

Step 6 Prescriber Information

***FIRST NAME:** _____ ***LAST NAME:** _____

***PRACTICE NAME:** _____

***STREET:** _____ SUITE: _____

***CITY:** _____ ***STATE:** _____ ***ZIP:** _____

PRESCRIBER TAX ID # : _____ PRESCRIBER NPI† ID #: _____ GROUP NPI† ID #: _____

OFFICE CONTACT: _____ OFFICE CONTACT EMAIL: _____

OFFICE CONTACT PHONE: (_____) _____-_____ OFFICE CONTACT FAX: (_____) _____-_____

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), benefits re-verification, 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.

- If you are seeking support for Infused or SC therapy, **fax pages 1 and 2 to (888) 249-4919**
- If you are seeking support for Oral or Starter therapy, please **continue to page 3**

†National Provider Identifier.

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ORAL PRODUCTS ONLY - Complete all fields for prescribed therapy

Step 8 Patient Information (please re-enter)

***FIRST NAME:** _____ ***LAST NAME:** _____ ***DOB (MM/DD/YYYY):** ____/____/____

Step 9 Prescription Information

For ALECENSA® (alectinib) patients

Metastatic non-small cell lung cancer (NSCLC)? ☐ Yes ☐ No

Positive for anaplastic lymphoma kinase (ALK)? ☐ Yes ☐ No

Prescription ☐ 600 mg twice daily ☐ Other: _____

DISPENSE: _____-MONTH SUPPLY REFILL: _____ TIMES

ALECENSA SureStart® free starter supply ☐ 600 mg twice daily

DISPENSE: 1-MONTH SUPPLY ☐ REFILL: 1 TIME

For COTELLIC® (cobimetinib) patients

Unresectable/metastatic melanoma? ☐ Yes ☐ No

Used in combination with ZELBORAF® (vemurafenib)? ☐ Yes ☐ No
(If yes, complete ZELBORAF section to the right)

Prescription ☐ 60 mg daily for 21 consecutive days on, followed by a 7-day rest period

☐ Other : _____

DISPENSE: _____-MONTH SUPPLY REFILL: _____ TIMES

Confirmed positive for BRAF V600E? ☐ Yes ☐ No

Confirmed positive for BRAF V600K? ☐ Yes ☐ No

For Erivedge® (vismodegib) patients

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

Prescription ☐ 150 mg daily ☐ Other: _____

DISPENSE: _____-MONTH SUPPLY REFILL: _____ TIMES

For ROZLYTREK® (entrectinib) patients

Metastatic non-small cell lung cancer (NSCLC)? ☐ Yes ☐ No

Positive for ROS1? ☐ Yes ☐ No

Locally advanced or metastatic solid tumors? ☐ Yes ☐ No

Positive for neurotropic tropomyosoin receptor kinase (NTRK) fusions without a known acquired resistance? ☐ Yes ☐ No

Progression following prior therapy or initial therapy when no satisfactory alternative therapy? ☐ Yes ☐ No

Lab test type?

☐ Next-generation sequencing (NGS) ☐ Polymerase chain reaction (PCR)

☐ Fluorescence in situ hybridization (FISH) ☐ Immunohistochemistry (IHC)

Prescription ☐ 150 mg daily ☐ Other: _____

DISPENSE: _____-MONTH SUPPLY REFILL: _____ TIMES

SureStart free starter supply ☐ 600 mg once daily ☐ Other: _____

DISPENSE: 1-MONTH SUPPLY ☐ REFILL: 1 TIME

For XELODA® (capecitabine) patients

Attach prescription

For ZELBORAF® (vemurafenib) patients

Unresectable/metastatic melanoma? ☐ Yes ☐ No ☐ Other

Confirmed positive for BRAF V600E? ☐ Yes ☐ No

Prescription ☐ 960 mg twice daily for 21 days, 720 mg twice daily thereafter

☐ 960 mg twice daily

☐ Other: _____

DISPENSE: _____-MONTH SUPPLY REFILL: _____ TIMES

Step 10 Prescriber Certification

By signing 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 you are prescribing a Genentech product is not listed in the FDA-approved label, you are 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 initiating or continuing therapy, as a break in treatment would negatively impact the patient's therapeutic outcome and (d) I will not attempt to seek reimbursement for free product provided to the patient. I request Genentech Access Solutions convey to the pharmacy chosen by the above-named patient the prescription described herein. (e) The services you are requesting on behalf of the patient, may include benefits investigation (BI), benefits re-verification, prior authorization support (PA), co-pay card and co-pay assistance foundation referral. In the absence of a checkbox selecting a service, we 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. (g) For prescribers in states with official prescription form requirements, such as New York, prescriptions must be submitted on an official state prescription pad along with this enrollment form.**

Sign, date & fax to **(877) 313-2659**

***Prescriber's Signature:** _____ ***Date:** ____/____/____
(Original or stamped signature required)

Required field (*)