

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: _____

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 Patient's Therapy (check all that apply)

Rituxan® (rituximab)

SIG: Infuse: _____ mg
 Day 1 and day 15
 Once a week for 4 weeks
 Other: _____
 Dispense Rituxan vials:
 _____ 100-mg dose
 _____ 375-mg dose
 _____ 500-mg dose
 Refill _____ times

ACTEMRA® (tocilizumab) intravenous (IV) infusion

SIG: Infuse: _____ mg
 Once every 2 weeks Once every 4 weeks Other: _____
 Dispense ACTEMRA vials: _____ 80-mg dose _____ 200-mg dose _____ 400-mg dose
 Patient weight: _____ lbs Refill _____ times

ACTEMRA subcutaneous (SC) self-injectable

Prefilled syringe Autoinjector (ACTPen®)
Inject 162-mg
 Once a week Once every 2 weeks Other: _____
 Dispense:
 1 month 2 months 3 months Other: _____
 Patient weight: _____ lbs Refill _____ times

Step 4 Diagnosis and Clinical Information

To the highest level of specificity, provide:

*Primary diagnosis code: _____

Anticipated date of treatment: ____ / ____ / ____

Secondary diagnosis code: _____

Has the patient started therapy? Yes No



Please continue to Step 5 on the next page.

for **Rituxan®** & **ACTEMRA®**
(rituximab) (tocilizumab)

SUBMIT ONLY REQUESTED DOCUMENTS

Required field (*) ACS/010319/0002 02/19

Step 5 Patient Information (please re-enter)

*First name: _____ *Last name: _____ *Date of birth (MM/DD/YYYY): ____ / ____ / ____

Step 6 Acquisition and Administration Information

Specialty pharmacy needed for Rituxan® (rituximab) or ACTEMRA® (tocilizumab) dispensing? Yes No (physician's office will supply)

Preferred specialty pharmacy: _____

Place of infusion: Prescribing physician's office Other physician's office Hospital outpatient Other: _____

Infusion site name: _____ Infusion site tax ID #: _____

Infusion site NPI† #: _____ Street: _____ Suite: _____

City: _____ State: _____ ZIP: _____

Step 7 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 8 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.**



- If you are seeking support services for starter therapy or ACTEMRA subcutaneous, please continue by completing the step below and providing a prescriber signature. Once signed and dated, fax pages 1 and 2 to (866) 681-3288
- Otherwise, no signature is needed. Please fax pages 1 and 2 to (866) 681-3288

Step 9 Starter Request

ACT Fast free starter supply only (ACTEMRA subcutaneous patients only)

Drug: ACTEMRA subcutaneous self-injectable 162-mg

Prefilled Syringe Autoinjector (ACTPen®)

Dispense: 15-day supply Once every week Once every 2 weeks Patient weight: _____ lbs Refill _____ times



Sign, date & fax to
(866) 681-3288

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

†National Provider Identifier.

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