Genentech | Access Solutions
A Member of the Roche Group

for VENCLEXTA®
(venetoclax tablets)

Prescriber Service Form

SUBMIT ONLY REQUESTED DOCUMENTS

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

Required field (*) **M-US-00005342(v4.0)**

Step 1 Patient Information

SERVICES REQUESTED
(Check all that apply):

- ☐ **Benefits Investigation (BI) & Prior Authorization (PA) Support**
- ☐ **Co-pay Referrals**
  - – Genentech co-pay card
  - – Co-pay assistance foundation
- ☐ **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: _____

Patient preferred language: ☐ English ☐ Spanish ☐ Other: _____

Alternate contact name: _____

Relationship: _____ Alt phone: (___) ___-____

Step 2 Insurance Information

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 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/Policy ID #			
Group #			
Insurance phone			

Step 3 Patient's VENCLEXTA Therapy

List medications used in combination with VENCLEXTA for a regimen benefits investigation:

☐ See attached medication list

_____

_____

_____

_____

_____

Note: VENCLEXTA has a limited distribution network. See details at **Genentech-Access.com/VENCLEXTA** or call (888) 249-4918 for support.

Dispense VENCLEXTA through:

☐ Specialty pharmacy (SP) ☐ Onsite pharmacy

Preferred SP: _____

Infused Site of Treatment (if not prescriber):

☐ Physician's office ☐ HOPD ☐ Alternate treatment center

Name: _____

Tax ID: _____ NPI #: _____

Step 4 Diagnosis and Clinical Information

Diagnosis Code

To the highest level of specificity, provide:

***Primary diagnosis code:** _____

Secondary diagnosis code: _____

Clinical Information

Has treatment started? ☐ Yes ☐ No Date of treatment: __/__/____

Line of therapy: ☐ First ☐ Second ☐ Third or greater

Please continue to Step 5 on the next page.

HOPD=hospital outpatient department; NPI=National Provider Identifier.

Genentech | Access Solutions
A Member of the Roche Group

for VENCLEXTA®
(venetoclax tablets)

Prescriber Service Form

SUBMIT ONLY REQUESTED DOCUMENTS

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

Required field (*) M-US-00005342(v4.0)

Step 5 Patient Information (please re-enter)

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

Step 6 Prescriber Information

***First name:** _____ ***Last name:** _____

***Practice name:** _____

***Street:** _____ ***Suite:** _____

***City:** _____ ***State:** _____ ***ZIP:** _____

Prescriber NPI #: _____ Group NPI #: _____ Prescriber tax ID #: _____

Office contact: _____ Office contact email: _____

Office contact phone: (___) ___ - _____ Office 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 7 Prescription Information for VENCLEXTA only

***Please fill out the prescription information for the indication that applies.**

CLL/SLL

Step 1: Ramp-up Dosing

☐ **Starting pack** (Contains 4 weekly wallet blister packs. Take as directed on PI.)

Treatment Week	Dosing Instruction From PI
Week 1	20 mg
Week 2	50 mg
Week 3	100 mg
Week 4	200 mg

Dispense: 1-month supply

Step 2: Maintenance

☐ Daily dose: _____ mg | Dispense: 1-month supply ☐ Refill: 1 time

AML

Step 1: Ramp-up Dosing

☐ Day 1: _____ mg | Day 2: _____ mg | Day 3: _____ mg

Step 2: Maintenance

☐ Daily dose: _____ mg | Dispense: 1-month supply ☐ Refill: 1 time

Other Dosing

Step 1: Ramp-up Dosing

☐ Specify dose ramp up: _____

Dispense: 1-month supply ☐ Refill: 1 time

Step 2: Maintenance

☐ Daily dose: _____ mg | Dispense: 1-month supply ☐ Refill: 1 time

VENCLEXTA SureStart®

Opt in below to consider your patient for this option: If your patient does not receive a coverage decision within 5 business days, he or she may be eligible for a SureStart supply while awaiting insurance verification. SureStart supplies the first 4 weeks of medicine. If the coverage decision is delayed past 3 weeks, we will follow up for 1 refill. Your VENCLEXTA representative can provide more information. Call (888) 249-4918 for more information.

☐ **Yes, consider this patient for SureStart in the event of a payer delay**

For full eligibility criteria and Terms and Conditions, please visit **www.genentech-pro.com/starter** or speak to your VENCLEXTA representative. Genentech reserves the right to rescind, revoke or amend the Programs without notice at any time.

Step 8 Health Care Provider 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)

AML=acute myeloid leukemia; CLL=chronic lymphocytic leukemia; NPI=National Provider Identifier; PI=prescribing information; SLL=small lymphocytic lymphoma.

VENCLEXTA® is a registered trademark of AbbVie, Inc.

abbvie | Genentech