Genentech
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for GAZYVA® (obinutuzumab), Rituxan® (rituximab) & ACTEMRA (tocilizumab)

Immunology Prescriber Service Form

SUBMIT ONLY REQUESTED DOCUMENTS

Required field (*) **M-US-00006696(v5.0)**

Step 1 Patient Information

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

***Date of birth (MM/DD/YYYY):** ____/____/_____ Gender: ☐ Male ☐ Female

Street: _____ Apt: _____

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

Phone: (____) ____-_____ ☐ Cell ☐ Home ☐ Do not contact patient

Email: _____ Preferred language: ☐ English ☐ Spanish ☐ Other: _____

Alternate contact name: _____ Relationship: _____ Phone: (____) ____-_____

Step 2 Insurance Information

Is the patient insured? ☐ Yes ☐ No

If patient is uninsured, please complete the Prescriber Foundation Enrollment Form here or call (888) 941-3331 for assistance.
If insured, please fill out the information below or attach a copy of the patient's health insurance cards.

Is prior authorization in place? ☐ Yes ☐ No Authorization #: _____

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

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

☐ **GAZYVA® (obinutuzumab) intravenous (IV) infusion**

Infuse 1000 mg
☐ Weeks 1, 2, 24, and 26
☐ Every 6 months
☐ Other: _____
☐ Dispense GAZYVA vials:
____ 1000-mg dose
Refill _____ times

☐ **Rituxan® (rituximab) intravenous (IV) infusion**

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: _____ lb
Refill _____ times

☐ **ACTEMRA® (tocilizumab) 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: _____ lb
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

Step 5 Acquisition and Administration Information

Specialty pharmacy needed for GAZYVA, Rituxan, or ACTEMRA dispensing? ☐ Yes ☐ No (Place of infusion will supply)

Preferred specialty pharmacy: _____

Place of infusion: ☐ Physician's office ☐ Hospital outpatient ☐ Infusion center ☐ Other: _____

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

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

City: _____ State: _____ ZIP: _____

†National Provider Identifier.

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Step 6 Patient Information (please re-enter)

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

Step 7 Prescriber Information

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

***Practice name:** _____

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

***State:** _____ ***ZIP:** _____ Prescriber tax ID #: _____

☐ Rheumatologist ☐ Nephrologist ☐ Other specialty

Prescriber NPI† #: _____ Group NPI† #: _____ Prescriber email: _____

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**.

†National Provider Identifier.

Step 8 GAZYVA, Rituxan, and ACTEMRA Immunology Co-pay Program Enrollment Criteria

☐ **By checking this box, I certify that:**

- I have the patient's consent to enroll in the GAZYVA® (obinutuzumab), Rituxan® (rituximab), or ACTEMRA® (tocilizumab) Immunology Co-pay Program for assistance with drug out-of-pocket costs and/or Genentech GAZYVA, Rituxan, or ACTEMRA administration out-of-pocket costs
- The patient is not using and I will not bill any federal or state-funded healthcare program. This includes, but is not limited to, Medicare, Medicaid, Medigap, VA, DoD, and TRICARE
- The patient is not currently receiving Genentech GAZYVA, Rituxan, or ACTEMRA drugs 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 GAZYVA, Rituxan, and ACTEMRA Immunology Co-pay Program
- Genentech reserves the right to rescind, revoke, or amend the program without notice at any time
- I have read and accepted the full GAZYVA Program Terms and Conditions as found on the following link: GAZYVAimmunologycopay.com/hcp/terms-and-conditions
- I have read and accepted the full Rituxan and ACTEMRA Program Terms and Conditions as found on the following link: RACopay.com/hcp/terms-and-conditions

Step 9 Healthcare Provider Certification

BY SUBMITTING THIS FORM:

I am requesting services on behalf of the patient, which may include benefits investigation and reverification, help navigating the prior authorization process, and appeals support

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.**