Instructions for Patients

By completing this form you can:

Learn about your health insurance coverage and other options to get your Genentech medicine

Enroll into optional disease-specific education, patient support services and communication

We can start helping you once we receive this form from you or your health care provider.
You can choose not to sign this form. However, we cannot help you unless you sign the authorization.

Please follow these steps so we can start helping you:

Read pages 2 and 3 of this form.

Complete and sign the following sections on page 4:

- Section 1 and 1A to enroll in all services
- Section 1B to enroll in in-home injection training and educational and marketing programs
- Section 1C to see if you are eligible for free medicine from the Genentech Patient Foundation

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Genentech can start helping you when page 4 of this form is submitted by you or your doctor's office in one of the following ways:

Complete online at ENSPRYNG.com/Forms

OR

Take a photo and text it to (650) 877-1111

OR

Print, complete and fax it to (844) 677-0010

If you have any questions, talk to your health care provider or contact Genentech Access Solutions for ENSPRYNG by calling (844) 677-7964.

Helpful Terminology

Genentech: The maker of the medicine your doctor wants to prescribe. Genentech is committed to helping patients get the medicine their doctor prescribed.

Genentech Access Solutions: A team at Genentech that works with your doctor and health insurance plan to help you get your medicine.

Genentech Patient Foundation: A program that gives free Genentech medicine to people who don't have insurance coverage or who have financial concerns and meet certain eligibility criteria.

Patient Navigator: Your personal guide throughout your treatment with a Genentech medicine. They will take you through the process and help you along the way.

Household size: Number of people living in your household, including you.

Household income: How much you and the members of your household currently make each year minus specific deductions. This is also known as your Adjusted Gross Income or AGI. This information is needed to find out if you are eligible for help from the Genentech Patient Foundation.

Patient education and treatment resources: Optional programs offered by Genentech to help you start and stay on your medicine. Services may vary based on your medical condition and could include co-pay assistance, clinical support, in-home injection training, marketing communication and general disease information.

Deductible: The amount you pay for health care services or medicines out of pocket before your health insurance plan begins to pay.

Out-of-pocket costs: The amount not paid by the insurance plan that you must pay for your treatment. This includes deductibles, co-pays and co-insurance.

Co-pay assistance: Programs available to help eligible patients pay for their medicines.

Alternate contact: Someone you choose to be your contact person if Genentech Access Solutions cannot reach you.

Personally identifiable information (PII): Any information that can be used to directly or indirectly identify you or your household. This might include your name, birthdate, address, telephone number, email address, financial information, medical condition or information about your health benefits or insurance coverage.

Specialty pharmacy (SP): An SP supplies certain medicines for patients. Some plans require you to use a certain SP to receive your medicine. SPs send your medicine to your doctor's office or your home. They may also offer other services, such as referrals to financial assistance.

Terms and Conditions for Receiving Free Genentech Medicine:

- I will not sell or give out this medicine since it is unlawful to do so. I am responsible to make sure these medicines are sent to a secure address when shipped to me, and I must control any Genentech medicine that I receive
- I understand that, for purposes of an audit, the Genentech Patient Foundation could ask me for a copy of my IRS 1040 form or other proof of income

About Your Consent

Who May See and Use My PII

I authorize Genentech and/or Genentech Patient Foundation to (i) use my PII for the purpose of facilitating my access to Genentech products and providing the services described below, and (ii) further disclose my PII to others who are assisting them in these services, and to my health care provider(s), health care entities, pharmacies, and health plan(s) for purposes of providing these services. Some of these disclosures may constitute a sale of PII. If so, I have the right to opt out of the sale of my PII if I reside in California. Additional information regarding my privacy rights can be found in Genentech's website privacy policy (www.gene.com/privacy-policy).

Reasons for sharing and using my information may include:

- Working with my health care plan to understand coverage for Genentech products
- Applying to the Genentech Patient Foundation
- Determining my eligibility and enrollment into financial assistance services, including co-pay assistance
- Coordinating my prescription through a pharmacy, infusion site and/or health care provider's office
- Providing treatment reminders and education

I direct and authorize my physician, pharmacy and my health plan(s) to disclose my PII to Genentech and its partners, as necessary for Genentech to provide the above services.

Once I sign this Patient Consent Form and my PII is transmitted to Genentech and/or Genentech Patient Foundation, I understand that the Health Insurance Portability and Accountability Act (HIPAA) may no longer protect or prohibit the redisclosure of the PII disclosed to Genentech and/or Genentech Patient Foundation by my health care provider or others covered by the HIPAA laws. I understand that Genentech and Genentech Patient Foundation are committed to protecting my information and keeping it secure and confidential while it is being collected or used to assist me and that the use and disclosure of my information will be limited to that described above. I can choose not to sign this form, but Genentech and Genentech Patient Foundation will not be able to assist me without it. However, my health care providers and health insurer may not condition either my treatment or my payment, enrollment or eligibility for benefits on signing this form.

The length and terms of this form

- This form is valid for 3 years from the date I signed or the date I last enrolled, whichever comes first, unless a shorter period is required by law
- I agree that if I reside in the state of Maryland, this form will be valid for no longer than 1 year from the date I signed
- I have the right to cancel this authorization. If I cancel, this means that Genentech and/or the Genentech Patient Foundation will no longer use or share my PII, but this will not apply to PII already used or shared or when it is required by law. If I reside in California, I also have the right to request that Genentech and/or the Genentech Patient Foundation delete my PII, although deletion is not required under certain circumstances. To cancel or request deletion, I must send a written notice to Genentech. It can be sent by fax or by mail to the address below. If I cancel and request deletion, I know that Genentech and the Genentech Patient Foundation will no longer be able to assist me with access to my Genentech products
- I understand that I, as the patient or signer, have a right to receive a copy of this signed form over the time it is valid

Address: Genentech, Inc., 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990

Patient Consent Form—to be filled out by patient

SECTION 1: Patient Information

First name*

Last name*

_____/_____/_____
Date of birth* (MM/DD/YYYY)

Preferred form of communication
(check all that apply)

☐ Email: _____

☐ Home phone‡: (_____)_____-_____

☐ Cell phone‡: (_____)_____-_____

A detailed message can be left to all numbers provided and/or all authorized individuals.

OK to leave detailed voice message?
☐ Yes ☐ No

OK to send a text message?
☐ Yes ☐ No

Best time to reach me:
☐ Morning ☐ Afternoon

Patient preferred language

Alternate contact name

Relationship to patient

Phone: (_____)_____-_____

Email: _____

1A

Patient authorization via signature is required to obtain services from Genentech Access Solutions for ENSPRYNG and Genentech Patient Foundation. By signing this box, you agree to the terms in the "About Your Consent" section.

Sign and date here

_____ _____/_____/_____
Signature of patient/authorized person* Date signed* (MM/DD/YYYY)

_____ _____
Print first name† Print last name†

_____
Relationship to patient (required if not the patient)

1B

Patient consent to enroll in:
☐ Injection Training Program
☐ Educational and marketing programs, which includes market research and communication that may be considered marketing

I understand that my PII may be needed for me to participate in these programs.

Choose to enroll by signing and dating here

_____ _____/_____/_____
Signature of patient/authorized person Date signed (MM/DD/YYYY)

‡By providing my phone number and signing Section 1B, I authorize Genentech to use auto-dialers or prerecorded and artificial voice to contact me. I understand that these calls/texts may mention the name of Genentech products or services, details about my insurance coverage and my doctor's name. I understand that I am not required to consent to being contacted by phone or text message as a condition of any purchase of Genentech products or enrollment. Message and data rates may apply. I understand that I may opt out of receiving these communications at any time by calling (877) GENENTECH (877-436-3683).

1C

Financial Eligibility Information: Complete for Genentech Patient Foundation only.
By completing this section, I am agreeing to the terms and conditions of the Genentech Patient Foundation outlined on page 2.

Household size (including you): _____

Annual household income:
☐ Under $75,000
☐ $75,000–$100,000
☐ $100,001–$125,000
☐ $125,001–$150,000
☐ Over $150,000

Choose to enroll by signing and dating here

_____ _____/_____/_____
Signature of patient/authorized person Date signed (MM/DD/YYYY)

(Required if requesting assistance from the Genentech Patient Foundation)