Genentech | Access Solutions
A Member of the Roche Group

for ENSPRYNG®
satralizumab-mwge

# ENSPRYNG Start Form

Phone: (844) 677-7964 Fax: (844) 677-0010 Text: (650) 877-1111
Genentech-Access.com/ENSPRYNG
M-US-00003211(v4.0)

## Instructions for Patients

### By completing this form, you can:

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

Sign up to receive optional disease education and other material

### Please follow these 3 steps to get started:

1. Read "Authorization to Use and Disclose Personal Information" on page 3.
2. Sign and date page 4. Please note you must sign the form to get support for your treatment.
3. Send in your completed form using one of the options below.

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

Complete online by scanning this QR code or visiting **ENSPRYNG.com/Forms**

OR

Print, complete, 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 call ENSPRYNG Access Solutions at (844) 677-7964.

## Instructions for Health Care Providers

**Please write legibly and complete all required fields (*) on the ENSPRYNG Start Form to prevent delays.**

### By completing this form, you are requesting services on behalf of your patient, which may include:

- Benefits investigation
- Benefits reverification every 6 months
- Assistance with the prior authorization process and appeals resources
- Referral to co-pay support options

To request assistance from the Genentech Patient Foundation, please complete the Prescriber Foundation Form at GenentechPatientFoundation.com.

**You may opt out of any of these services** for your patient by contacting ENSPRYNG Access Solutions at (844) 677-7964.

### To enroll your patient, please follow these steps:

- Have your patient read pages 2 and 3
- Have your patient complete page 4
- Complete page 5
- Send pages 4 and 5 via one of the following options:
  - My Patient Solutions® for Health Care Practices at **Genentech-Access.com/MPS**
  - eSubmit at **ENSPRYNG.com/Forms**
  - Fax at (844) 677-0010

  Page 4 can also be sent via text according to the instructions above.

**Diagnosis Code and Clinical Information:** Enter the diagnosis code to the highest level of specificity.

**Injection Training:** Make sure the patient checks the boxes in section 2 and signs page 4 to request nurse support for injection training for ENSPRYNG.

## 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. When used on this form, the term "Genentech" refers to Genentech, Genentech Patient Foundation, and their respective partners, affiliates, subcontractors and agents.

**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 health 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.

**Net household income:** How much you and the members of your household currently make each year minus specific deductions. This is also frequently referred to as your Adjusted Gross Income or AGI. This information is needed to determine Genentech Patient Foundation eligibility.

**Education and patient support services: 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, 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 health insurance plan that you must pay for your treatment. This includes premiums, 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. An Alternate Contact may not be an individual associated with or a representative of your insurance company, employer, or a business partner of your insurance company or employer.

**Legally authorized representative:** An individual or judicial or other body authorized under applicable law to consent on behalf of a patient (e.g., a parent or legal guardian of a minor).

**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 of the Genentech Patient Foundation

- If I receive free medicine from the Genentech Patient Foundation, I will not sell or give out this medicine because it is illegal to do so. I am responsible to ensure that the medicine is sent to a secure address when shipped to me, and I must control any 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
- Some insurance plans and/or employers partner with organizations known as alternate funding programs. Such arrangements require patients to apply to the Genentech Patient Foundation as a condition of, or prerequisite to, coverage of relevant Genentech products. These alternate funding programs include SHARx, Paydhealth, and Payer Matrix, among others. Patients whose insurance plans and/or employers use an alternative funding program are ineligible for support from the Genentech Patient Foundation
- I acknowledge that, to the best of my knowledge, neither my insurance plan nor my employer (1) required me to apply to the Genentech Patient Foundation and/or (2) changed or hid my insurance coverage for my Genentech medicine to make me appear to be underinsured and eligible for support from the Genentech Patient Foundation. I am not applying to the Genentech Patient Foundation on behalf of someone whose insurance plan and/or employer partners with an alternative funding program. The Alternate Contact listed on my application (if any) is not associated with or a representative of my insurance company, employer, or a business partner of my insurance company or employer. If I subsequently learn that my insurance plan and/or employer uses an alternative funding program, I agree to inform the Genentech Patient Foundation immediately and understand that I will no longer be eligible for support

## Authorization to Use and Disclose Personal Information

I authorize my physician(s) and their staff, pharmacies, and health insurance plan (my "health care providers") to share my personal information, which may include contact information, demographic information, financial information, and information related to my medical condition, treatments, and health insurance and benefits, with Genentech, Genentech Patient Foundation, and their respective partners, affiliates, subcontractors, and agents (together, "Genentech"). I authorize Genentech to receive, use, and share my personal information in order to provide me with access to the products, services, and programs described on this form, which may include the following:

- Working with my health insurance plan to understand or verify coverage for Genentech products
- Applying to the Genentech Patient Foundation
- Determining my eligibility for and facilitating enrollment into financial assistance services if I'm eligible, including co-pay assistance
- Coordinating my prescription through a pharmacy, infusion site and/or health care provider's office. This includes contacting me to discuss my coverage, costs and eligibility for assistance and other program administration purposes
- Facilitating my access to Genentech products
- Ensuring quality and safety and improving our products and services
- Contacting me by mail, e-mail, telephone calls and text messages at the number(s) and address(es) provided for non-marketing purposes
- If I agree to the **optional** Consent for Patient Resources and Information, providing me with **optional** disease information and marketing material about products, services and programs offered by Genentech, its partners and their respective affiliates. This is not required to enroll into Genentech Access Solutions services
- If I agree to the **optional** Telephone Consumer Protection Act (TCPA) Consent, contacting me by autodialed calls and/or text messages at the phone number(s) I have provided for marketing purposes. This is not required to enroll into Genentech Access Solutions services

I understand that this will include sharing and use of information about me that could be considered sensitive personal information, such as health conditions, but that the use of this information by Genentech is necessary to determine if I qualify for and to administer the benefits and services for which I am applying. I understand that Genentech may also share my personal information, including sensitive personal information, for the purposes described on this authorization with my health care providers, service providers, and any individual I may designate as an alternate contact. I understand that my pharmacy may receive payment or other remuneration for disclosing my personal information pursuant to this authorization. I can choose not to sign this authorization, but Genentech will not be able to provide the services to me without it. However, my health care providers may not condition either my treatment or my payment, enrollment, or eligibility for benefits on signing this authorization.

I also understand and agree that:

- This authorization is valid for 6 years from the date I sign or the date I last enrolled, whichever comes first, unless a shorter period is required by law, or I revoke it earlier
- My personal information released under this authorization may no longer be protected by state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA). However, Genentech will only use and share my personal information for the purposes stated on this authorization or as otherwise permitted by law
- I have the right to revoke (cancel) this authorization at any time by submitting a written notice to: Genentech Access Solutions, 1 DNA Way, South San Francisco, CA 94080-4990 or by calling **(866) 422-2377**. If I revoke this authorization, I will no longer be eligible for the services described. If a health care provider is disclosing my personal information to Genentech on an authorized, ongoing basis, my revocation will be effective with respect to such health care provider when they receive notice of my revocation. My revocation will not impact uses and disclosures of my personal information that have already occurred in reliance on this authorization
- More information on my privacy rights, including specific rights I may have as a resident of certain states, can be found in Genentech's privacy policy (**www.gene.com/privacy-policy**)
- I have a right to receive a copy of this authorization

## Patient Information (to be completed by patient or their legally authorized representative)

*First name: _____ *Last name: _____

Home phone: (  ) - _____ Cell phone: (  ) - _____

☐ OK to leave a detailed message? Date of birth (MM/DD/YYYY) __/__/____

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

Alternate Contact (optional) Full name: _____

Relationship: _____ Phone: (  ) - _____

**1**

### Financial Eligibility: Complete **only** if you are applying to the Genentech Patient Foundation

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: _____

**2**

### Consent for Patient Resources and Information (**OPTIONAL**)

Genentech offers **optional** and free disease education and other material for patients. This may include information and marketing material about products, services and programs offered by Genentech, its partners and their respective affiliates. If you sign up, you may be contacted using the information you have provided.

☐ By checking this box, I agree to receive **optional** disease education and other material. I understand providing this agreement is voluntary and plays no role in getting Genentech Access Solutions services or my medicine and that it may be necessary to use my sensitive personal information to provide me with relevant material. I also understand that I may opt out of receiving this information at any time by calling **(877) 436-3683** and that this consent will remain active unless I opt out.

### Telephone Consumer Protection Act (TCPA) Consent (**OPTIONAL**)

☐ By checking this box, I consent to receive autodialed marketing calls and text messages from and on behalf of Genentech at the phone number(s) I have provided. I understand that consent is not a requirement of any purchase or enrollment. Message frequency may vary. Message and data rates may apply. I may opt out at any time by texting STOP or calling **(877) GENENTECH** (877-436-3683).

**3**

By signing this form, I acknowledge that I have provided accurate and complete information and understand and agree to the terms of this form. My signature certifies that I have read, understood, and agree to the release and use of my personal information, including sensitive personal information, pursuant to the Authorization to Use and Disclose Personal Information and as otherwise stated on this form.

REQUIRED

**Sign and date here**

_____ *Signature of Patient/Legally Authorized Representative (A parent or guardian must sign for patients under 18 years of age)

__/__/____ *Date signed (MM/DD/YYYY)

**Person signing (if not patient)**

_____ Print first name

_____ Print last name

_____ Relationship to patient

**Once this page (4/5) has been completed,** please text a photo of the page to **(650) 877-1111**, or fax to **(844) 677-0010**. You can also complete this form online at **Genentech-Access.com/PatientConsent**.

If this is an electronic consent, you understand that by typing your name and the date above and submitting, or taking a picture and sending to us, that you are providing your consent electronically and that it has the same force and effect as if you were signing in person on paper. Genentech reserves the right to rescind, revoke or amend the program without notice at any time.

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*SUBMIT ONLY REQUESTED DOCUMENTS* *Required field.

## Prescriber Service Form (to be filled out by health care provider)

### STEP 1 Patient Information

☐ DO NOT CONTACT PATIENT

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

Street _____ City _____ State* _____ ZIP _____ Phone* (___) ___-____

### STEP 2 Acquisition/Fulfillment of Drug

Preferred specialty pharmacy (SP): _____

### STEP 3 Diagnosis Code and Clinical Information

Diagnosis code*: ☐ G36.0 Neuromyelitis optica [Devic] ☐ Other diagnosis code: _____

Has the patient started prescribed ENSPRYNG® (satralizumab-mwge)? ☐ Yes ☐ No

### STEP 4 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 front and back of the patient's insurance card(s).**

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

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

### STEP 5 ENSPRYNG Prescription

☐ Loading dose SIG: Dispense 3 (120 mg) prefilled syringes
Inject 120 mg SC at Weeks 0, 2, and 4

☐ Maintenance dose SIG: Dispense 1 (120 mg) prefilled syringe
Inject 120 mg SC every 4 weeks Refills: _____

☐ Drug allergies: _____

☐ No known allergies

Other medications: _____

### STEP 6 Prescriber Information

☐ Buy and bill ☐ Specialty pharmacy

First name* _____ Last name* _____ Practice name* _____

Street* _____ Suite # _____ City* _____ State* _____ ZIP* _____

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

Office contact name _____ Office contact phone (___) ___-____ 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 ENSPRYNG Co-pay Program Enrollment Criteria

☐ By checking this box, I certify that:

- I have the patient's consent to enroll in the Genentech ENSPRYNG Co-Pay Program for assistance with drug out-of-pocket costs and/or Genentech ENSPRYNG administration out-of-pocket costs
- The patient is not using and you will not bill any federal or state-funded health care program. This includes, but is not limited to, Medicare, Medicaid, Medigap, VA, DoD and TRICARE
- The patient is not currently receiving Genentech ENSPRYNG 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 Genentech ENSPRYNG 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 Program Terms and Conditions as found on the following link: **www.enspryngcopay.com/terms-and-conditions**

**BY SUBMITTING THIS FORM:**

I am requesting services on behalf of the patient, which may include benefits investigation and reverification, help navigating the PA 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)** My patient meets the criteria for the Genentech Patient Foundation and to the best of my knowledge, this patient has no prescription insurance coverage (including Medicaid, Medicare, or other public or private programs) for the Genentech medicine listed above, or is unable to afford the cost-sharing requirements associated with his/her insurance coverage for this medication. If the patient is enrolled in an insurance plan, the plan does not require the patient's application to the Genentech Patient Foundation and/or has not changed or hidden the patient's coverage for the Genentech medicine to make them appear to be underinsured and eligible for the Genentech Patient Foundation. **(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.**

NPI=National Provider Identifier; SC=subcutaneous.

 