GENENTECH
PATIENT FOUNDATION

Prescriber Foundation Form

Instructions

GenentechPatientFoundation.com

Complete online by scanning the QR code or visit **go.gene.com/EnrollQR**

Phone: (888) 941-3331 **Fax:** (833) 999-4363

*Required field M-US-00000344(v5.0)

Who is eligible?

The Genentech Patient Foundation gives free medicine to people who are:

Uninsured

With income under $150,000*

OR

Insured Without Coverage for a Genentech medicine†

With income under $150,000*

OR

Insured With Coverage for a Genentech medicine

- With an out-of-pocket maximum (set by the health insurance plan) that is more than 7.5% of the patient's yearly income
- With household size and income within the criteria listed to the right

Household Size	Yearly Income
1 person	Under $75,000
2 people	Under $100,000
3 people	Under $125,000
4 people	Under $150,000*

If none of the ***3 situations*** apply, or you are unsure of your patient's health insurance coverage, Genentech Access Solutions can help. Genentech Access Solutions provides helpful access and reimbursement support to assist your patients and practice.

Call **(866) 422-2377** or visit **Genentech-Access.com** for more information.

*For all patient types, add $25,000 for each extra person in households larger than 4 people.

†The Genentech Patient Foundation does not provide free medicine in the instance of an administrative error or a coverage restriction. Some exceptions may apply.

For a current list of the medicines supported by the Genentech Patient Foundation, please visit **GenentechPatientFoundation.com** or call **(888) 941-3331**.

Apply for Support

How to apply

The patient completes the **Patient Consent Form** (Box 1 and Box 2 required) and the prescriber completes Page 2 of the **Prescriber Foundation Form**. Be sure to submit the patient and prescriber forms together for fast and efficient processing.

	Patient Consent Form	Prescriber Foundation Form
Where to find	Genentech-Access.com/PatientConsent	GenentechPatientFoundation.com
How to submit	E-Submit My Patient Solutions® for Health Care Practices Text a photo to (650) 877-1111 Fax to (833) 999-4363	Quick Enroll by scanning the QR code or visiting go.gene.com/EnrollQR My Patient Solutions for Health Care Practices Fax to (833) 999-4363

What to expect after applying?

Once an eligibility determination has been made, both the patient and prescriber will be contacted to discuss the application outcome and any next steps.

This program is intended to assist patients who are living in the United States and are being treated by a US-licensed physician. We do not collect or require citizenship information.

GENENTECH
PATIENT FOUNDATION

Prescriber Foundation Form

Prescriber to Complete

GenentechPatientFoundation.com

Complete online by scanning the QR code or visit **go.gene.com/EnrollQR**

Phone: (888) 941-3331 **Fax:** (833) 999-4363

*Required field M-US-00000344(v5.0)

STEP 1 PATIENT ELIGIBILITY

*Please check one (refer to page 1 for details on each type):

- ☐ Uninsured
- ☐ **Insured** but lacks coverage for this medicine
- ☐ **Insured** with coverage but medicine is unaffordable

For insurance denials, provide denial date: ____ /____ /____

Denial reason (or attach copy of denial letter): _____

If unsure of patient's insurance status, please contact Genentech Access Solutions at (866) 422-2377.

STEP 2 PATIENT INFORMATION

*First Name: _____ *Last Name: _____

*Date of Birth: _____ /_____ /_____ Gender: ☐ Male ☐ Female

*Street: _____ Apt: _____

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

Phone: (_____) _____ - _____ Phone Type: ☐ Cell ☐ Home

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

☐ Do not contact patient Alternate Contact: _____

Relationship to patient: _____

Alt Contact Phone: (_____) _____ - _____ Phone Type: ☐ Cell ☐ Home

STEP 3 INSURANCE INFORMATION: IF PATIENT HAS ANY INSURANCE, COMPLETE THIS SECTION OR ATTACH COPIES OF INSURANCE CARD(S).

	Primary Insurance	Secondary Insurance	Pharmacy Benefit
Insurance name			
Type (Comm, Medicare, Medicaid)			
Subscriber name (if not patient)			
Subscriber/Policy ID #			
Group #			
Insurance phone			
Maximum out of pocket			

STEP 4 TREATMENT INFORMATION

*Genentech Medication(s): _____ *Primary Diagnosis Code: _____

Has Patient Started Therapy? ☐ Yes ☐ No Other Diagnosis Code(s): _____

STEP 5 SHIPMENT INFORMATION

*Please check one shipment option:

- ☐ **Upfront**—Patient-specific medicine delivered to patient's home, practice or site of treatment.
- ☐ **Replacement**—Prescriber treats with own inventory, to be replaced by foundation.

Shipment to: ☐ Patient ☐ Prescriber/Practice ☐ Third-Party Site of Treatment (list below)

The information below is only required if receiving Genentech medication shipment to a site of treatment.

Site of Treatment Name: _____

Street: _____ Suite: _____

City: _____ State: _____ ZIP: _____

Contact Name: _____

Contact Phone: (_____) _____ - _____ Contact Fax: (_____) _____ - _____

STEP 6 PRESCRIPTION INFORMATION

If preferred, you may attach a written prescription or submit the prescription electronically. Electronic prescriptions can be submitted through an e-prescribing software or an electronic medical record that has been certified by Surescripts. Query for Medvantx or AmeriPharm in Sioux Falls, SD 57014. NPI-1073692745 or NCPDP-4351968.

Genentech Medication(s)	Size/Strength	Quantity	Frequency/Directions (for weight-based medications, please include exact dose or patient weight)	Refills
				☐ 1 year ☐ Other: _____

Drug Allergies: ☐ No Known ☐ Other: _____

Other Medications Prescribed: _____

STEP 7 PRESCRIBER INFORMATION

*First Name: _____ *Last Name: _____

Practice Name: _____ **Prescriber NPI #:** _____

*Street: _____ Suite: _____

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

Office Contact Name: _____ 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**.

STEP 8 HEALTH CARE PROVIDER CERTIFICATION

By signing below, I am agreeing to the following: (A) The Genentech medicine listed above is medically necessary for this patient. **(B)** I have received authorization to release the information above and other protected health information (as defined by HIPAA) to the Genentech Patient Foundation and its affiliates. **(C)** I will not seek reimbursement for free product provided to the patient. **(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/their 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)** I understand that Genentech reserves the right to modify or discontinue the program at any time and to verify the accuracy of information submitted. **(F)** If the indication for which you are prescribing a Genentech product is not listed in the FDA-approved label, you are prescribing the medicine for an "unapproved" use, meaning that the FDA has not approved the efficacy, dosage amount or safety of this medicine when used for such a use. The Genentech Patient Foundation may provide the medicine for your patient, based upon your medical order and within program requirements. **(G)** For insured patients, I understand that the Genentech Patient Foundation does not provide free drug in the instance of an administrative error or a coverage restriction such as a step edit. For certain products where the step edit may not be medically appropriate, as confirmed by the prescribing physician, the Genentech Patient Foundation may consider support following 1 level of appeal. **(H)** For prescribers in states with electronic prescription requirements, such as New York, prescriptions must be submitted via e-prescription directly to the pharmacy along with this enrollment form.

Sign, date and fax to (833) 999-4363

*Health Care Provider Signature: _____ *Date: _____ /_____ /_____

(Original or stamped signature required)

HIPAA=Health Insurance Portability and Accountability Act of 1996; NPI=National Provider Identifier.

 M-US-00000344(v5.0) Printed in USA