# Genentech Patient Foundation
# INSTRUCTIONS FOR ENROLLMENT

ACS/052918/0100(1) 10/18

GenentechPatientFoundation.com
**Genentech Patient Foundation:** (888) 941-3331
**Pharmacy and Shipment:** (833) 888-4363
**Fax:** (833) 999-4363

**6 a.m.–5 p.m. (PT) M-F**

## Are you eligible?

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

### Uninsured

No insurance and a household income of less than $150,000 each year

OR

### Insured, but Lack Coverage

Insurance that does not cover their Genentech medicine and a household income of less than $150,000 each year*

OR

### Insured, but Medicine Is Unaffordable

Insurance coverage for their Genentech medicine, but have trouble paying for their medicine even after using other assistance options, and a yearly household income of less than:

- $75,000 for a household of 1 person
- $100,000 for a household of 2 people
- $125,000 for a household of 3 people
- $150,000 for a household of 4 people

More than 4 people in your household? Add $25,000 for each additional person. There is no maximum number of people that you may add.

If none of the situations above apply or you are unsure of your insurance coverage, **Genentech Access Solutions** can help. **Genentech Access Solutions** is a program from Genentech and is committed to helping you understand your insurance coverage and options that might be able to help you pay for your Genentech medicine.

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

## How to apply

1. **Patient** fills out and signs **page 3**.
2. **Prescriber** fills out and signs **page 4**.
3. Completed application is faxed 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.

## Genentech medicines include:

**ACTEMRA®** (tocilizumab)
**ACTIVASE®** (alteplase)
**ALECENSA®** (alectinib)
**Avastin®** (bevacizumab)
**Cathflo®** Activase (alteplase)
**COTELLIC®** (cobimetinib)
**Erivedge®** (vismodegib)
**Esbriet®** (pirfenidone)
**GAZYVA®** (obinutuzumab)
**HEMLIBRA®** (emicizumab-kxwh)
**Herceptin®** (trastuzumab)
**KADCYLA®** (ado-trastuzumab emtansine)
**LUCENTIS®** (ranibizumab injection)
**OCREVUS®** (ocrelizumab)
**PERJETA®** (pertuzumab)
**Pulmozyme®** (dornase alfa) Inhalation Solution
**Rituxan®** (rituximab)
**RITUXAN HYCELA®** (rituximab/hyaluronidase human)
**Tarceva®** (erlotinib)
**TECENTRIQ®** (atezolizumab)
**TNKase®** (tenecteplase)
**VENCLEXTA®** (venetoclax)
**XOLAIR®** (omalizumab) for subcutaneous use
**ZELBORAF®** (vemurafenib)

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

# Genentech Patient Foundation
# PATIENT CONSENT INFORMATION

(To be completed by the patient or their legally authorized person)

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## Who may see and use my personally identifiable information (PII)

I am directing my health care provider(s) and/or health care plan(s) to share my health information with Genentech. I authorize Genentech to use and share my health information about my treatment with Genentech medicine. This may include information about my diagnoses and prescriptions and health care plan benefits. I authorize my health information to be shared with Agents, affiliates and vendors who are assisting Genentech and my health care provider(s), health care entities, pharmacies and health plan(s) for the purpose of helping me apply for support programs and get my Genentech medicine, including:

- Talking to my health care plan to understand my benefits and coverage situation
- Understanding if I might be eligible for other types of coverage and financial assistance for my Genentech medicine
- Processing shipment of my Genentech medicine through a pharmacy
- Administrative purposes to support Genentech Access Solutions and the Genentech Patient Foundation

## Receiving my Genentech medicine

If I receive free Genentech medicine from the Genentech Patient Foundation, I will not sell or give out this medicine since that is illegal. 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.

## What it means to sign this form

By signing this form, I understand:

- I, as a patient or signer, have a right to obtain a copy of this form
- This Authorization shall be in effect for 3 years from the date of my signature or the date of last enrollment, whichever comes first, unless a shorter period is required by law. I understand that if I am a resident of the state of Maryland, this Authorization will be valid for no longer than 1 year from the date I signed it
- Once I sign this form and my PII is transferred to Genentech and/or the Genentech Patient Foundation, the Health Insurance Portability and Accountability Act (HIPAA) may no longer protect my PII since Genentech is not covered by HIPAA. We know how important your PII is, and are committed to keeping it safe. We only use and share information for purposes described on page 1
- 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
- I may refuse to sign this form. I can cancel this Authorization at any time, which means that Genentech will no longer use my PII, but this does not apply to PII already shared. If you wish to cancel after signing, please send a written notice to Genentech at the fax number on this page. If I do cancel, Genentech can no longer help me get my Genentech medicine through these support programs

# Genentech Patient Foundation
# ENROLLMENT FORM

(To be completed by the patient or their legally authorized person)

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## Patient / Legally Authorized Person Signature

**Patient**

Print patient first name _____ Print patient last name _____ Date of birth ____/____/____ ZIP Code _____

Signature of patient/legally authorized person _____ Date signed _____
(A parent or guardian must sign for patients under 18 years of age)

**Person Signing (if not patient)**

Print first name _____ Print last name _____ Relationship to patient _____

## Eligibility Information

**Note:** The Genentech Patient Foundation **requires** the information below to track patient applications.

**How many people live in your household (include yourself)?** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: ____

**What range does your current household income fall into?**

☐ Under $75,000 ☐ $75,000 – $100,000 ☐ $100,001 – $125,000

☐ $125,001 – $150,000 ☐ Over $150,000 (list exact $ amount) _____

## Communication Preferences

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

How do you prefer to receive information? (please check all that apply)

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

☐ Email: _____

OK to leave a detailed message? (please check all that apply)

☐ Home ☐ Cell ☐ Do not leave message

OK to send a text message? ☐ Yes ☐ No

Best time to reach you via phone M-F: ☐ Morning ☐ Afternoon

Alternate contact name (if applicable): _____ Relationship to patient:_____

Phone: (_____) _____- _____ Email: _____

*By providing my phone number, I authorize Genentech to use auto-dialers, prerecorded messages and artificial voice messages 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 in Genentech Access Solutions or the Genentech Patient Foundation.

# Genentech Patient Foundation
# ENROLLMENT FORM (Prescriber to complete)

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## Patient Information

Patient First Name: _____ Patient Last Name: _____
Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female Phone: (_____) _____-_____
Address: _____ City: _____ State: _____ ZIP: _____
Patient Insurance (check one): ☐ **Uninsured** ☐ **Insured, but Lack Coverage** ☐ **Insured, but Medicine Is Unaffordable**
If Insured, Name of Insurance Provider: _____ Subscriber ID #: _____

## Prescriber Information

Prescriber First Name: _____ Prescriber Last Name: _____
Prescriber NPI: _____ Practice Name: _____
Practice Address: _____ City: _____ State: _____ ZIP: _____
Contact Name: _____ Phone: (_____) _____-_____ Fax: (_____) _____-_____
Email: _____

## Shipment Information

**Shipment Options:** ☐ **Upfront Shipments** (medicine is delivered to patient's home or practice through the foundation's pharmacy)
☐ **Product Replacement** (prescriber treats with their own inventory of medicine, which the foundation will replace)
**Shipment To:** ☐ **Patient** ☐ **Prescriber** ☐ **Site of Treatment:** _____
Site of Treatment Address: _____ City: _____ State: _____ ZIP: _____
Contact Name: _____ Phone: (_____) _____-_____ Fax: (_____) _____-_____
Email: _____

## Prescription Information

**Note: If preferred, you may attach a written prescription or submit the prescription electronically (please indicate below). 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-1235371535 or NCPDP-4354180.

Primary Diagnosis Code: _____ Secondary Diagnosis Code: _____ Tertiary Diagnosis Code: _____
Has the Patient Started Treatment? ☐ Yes ☐ No
Drug Allergies (check all that apply): ☐ No Known ☐ Aspirin ☐ Penicillin ☐ Other: _____
Other Medicines Prescribed: _____

| Genentech Medicine Requested | Size/Strength | Quantity | Frequency/Directions | Refills |
|---|---|---|---|---|
| | | | | ☐ 1 year<br>☐ Other: _____ |

**Prescription Submission Method (if not completed above):** ☐ **Written Prescription Attached** ☐ **Prescription Submitted Electronically**

## Prescriber Attestation

**By signing below, I am agreeing to the following:**

- The Genentech medicine listed above is medically necessary for this patient
- 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
- I will not seek reimbursement for free product provided to the patient
- My patient meets the criteria for the Genentech Patient Foundation
- I understand that Genentech reserves the right to modify or discontinue the program at any time and to verify the accuracy of information submitted
- 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
- 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
- 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 Here** _____ Signature of Prescriber

**Date Here** _____/_____/_____ Date

NPI=national provider identifier.