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Form **990-PF**

Department of the Treasury
Internal Revenue Service

Return of Private Foundation

or Section 4947(a)(1) Trust Treated as Private Foundation

▶ **Do not enter social security numbers on this form as it may be made public.**

▶ **Information about Form 990-PF and its separate instructions is at *www.irs.gov/form990pf.***

OMB No 1545-0052

2014

Open to Public Inspection

For calendar year 2014 or tax year beginning , 2014, **and ending** , 20

Name of foundation

Genentech Access to Care Foundation

A Employer identification number

46-0500266

Number and street (or P O box number if mail is not delivered to street address) | Room/suite

1 DNA Way, MS #24

B Telephone number (see instructions)

(866) 422-2377

City or town, state or province, country, and ZIP or foreign postal code

South San Francisco, CA 94080-4990

C If exemption application is pending, check here . . . . . ▶ ☐

G Check all that apply. ☐ Initial return ☐ Initial return of a former public charity ☐ Final return ☐ Amended return ☐ Address change ☐ Name change

D 1 Foreign organizations check here . . ▶ ☐

2 Foreign organizations meeting the 85% test, check here and attach computation . . . . . ▶ ☐

H Check type of organization: ☒ Section 501(c)(3) exempt private foundation ☐ Section 4947(a)(1) nonexempt charitable trust ☐ Other taxable private foundation

E If private foundation status was terminated under section 507(b)(1)(A), check here . ▶ ☐

I Fair market value of all assets at end of year *(from Part II, col. (c), line 16)* ▶ $ 40,371,925

J Accounting method: ☐ Cash ☒ Accrual ☐ Other (specify) _____ *(Part I, column (d) must be on cash basis)*

F If the foundation is in a 60-month termination under section 507(b)(1)(B), check here . ▶ ☐

Part I Analysis of Revenue and Expenses *(The total of amounts in columns (b), (c), and (d) may not necessarily equal the amounts in column (a) (see instructions))*

		(a) Revenue and expenses per books	(b) Net investment income	(c) Adjusted net income	(d) Disbursements for charitable purposes (cash basis only)
Revenue	1 Contributions, gifts, grants, etc , received (attach schedule)	590,076,170			
	2 Check ▶ ☐ if the foundation is **not** required to attach Sch B				
	3 Interest on savings and temporary cash investments				
	4 Dividends and interest from securities				
	5a Gross rents				
	b Net rental income or (loss)				
	6a Net gain or (loss) from sale of assets not on line 10				
	b Gross sales price for all assets on line 6a				
	7 Capital gain net income (from Part IV, line 2)		0		
	8 Net short-term capital gain			0	
	9 Income modifications				
	10a Gross sales less returns and allowances				
	b Less Cost of goods sold				
	c Gross profit or (loss) (attach schedule)				
	11 Other income (attach schedule)				
	12 **Total.** Add lines 1 through 11	590,076,170	0	0	
Operating and Administrative Expenses	13 Compensation of officers, directors, trustees, etc				
	14 Other employee salaries and wages				
	15 Pension plans, employee benefits				
	16a Legal fees (attach schedule)				
	b Accounting fees (attach schedule)				
	c Other professional fees (attach schedule)				
	17 Interest				
	18 Taxes (attach schedule) (see instructions)				
	19 Depreciation (attach schedule) and depletion				
	20 Occupancy				
	21 Travel, conferences, and meetings				
	22 Printing and publications				
	23 Other expenses (attach schedule)	20,437,181			20,437,181
	24 **Total operating and administrative expenses.** Add lines 13 through 23	20,437,181	0	0	20,437,181
	25 Contributions, gifts, grants paid	582,607,006			575,174,762
	26 **Total expenses and disbursements** Add lines 24 and 25	603,044,187	0	0	595,611,943
	27 Subtract line 26 from line 12				
	a **Excess of revenue over expenses and disbursements**	(12,968,017)			
	b **Net investment income** (if negative, enter -0-)		0		
	c **Adjusted net income** (if negative, enter -0-)			0	

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Part II Balance Sheets Attached schedules and amounts in the description column should be for end-of-year amounts only (See instructions)

		Beginning of year	End of year	
		(a) Book Value	(b) Book Value	(c) Fair Market Value
Assets	1 Cash - non-interest-bearing	0	0	0
	2 Savings and temporary cash investments			
	3 Accounts receivable ▶			
	Less allowance for doubtful accounts ▶	4,766,954	4,916,875	4,916,875
	4 Pledges receivable ▶			
	Less allowance for doubtful accounts ▶		0	
	5 Grants receivable			
	6 Receivables due from officers, directors, trustees, and other disqualified persons (attach schedule) (see instructions)			
	7 Other notes and loans receivable (attach schedule) ▶			
	Less allowance for doubtful accounts ▶		0	
	8 Inventories for sale or use	51,749,434	35,455,050	35,455,050
	9 Prepaid expenses and deferred charges			
	10a Investments - U S and state government obligations (attach schedule)			
	b Investments - corporate stock (attach schedule)			
	c Investments - corporate bonds (attach schedule)			
	11 Investments - land, buildings, and equipment basis ▶ Less accumulated depreciation (attach schedule) ▶		0	
	12 Investments - mortgage loans			
	13 Investments - other (attach schedule)			
	14 Land, buildings, and equipment basis ▶ Less accumulated depreciation (attach schedule) ▶		0	
	15 Other assets (describe ▶)			
	16 **Total assets** (to be completed by all filers - see the instructions Also, see page 1, item I)	56,516,388	40,371,925	40,371,925
Liabilities	17 Accounts payable and accrued expenses			
	18 Grants payable	10,608,798	7,432,244	
	19 Deferred revenue			
	20 Loans from officers, directors, trustees, and other disqualified persons			
	21 Mortgages and other notes payable (attach schedule)			
	22 Other liabilities (describe ▶)			
	23 **Total liabilities** (add lines 17 through 22)	10,608,798	7,432,244	
Net Assets or Fund Balances	**Foundations that follow SFAS 117, check here ▶ ☐ and complete lines 24 through 26 and lines 30 and 31.**			
	24 Unrestricted			
	25 Temporarily restricted	45,907,590	32,939,681	
	26 Permanently restricted			
	Foundations that do not follow SFAS 117, ▶ ☐ check here and complete lines 27 through 31.			
	27 Capital stock, trust principal, or current funds			
	28 Paid-in or capital surplus, or land, bldg , and equipment fund			
	29 Retained earnings, accumulated income, endowment, or other funds			
	30 **Total net assets or fund balances** (see instructions)	45,907,590	32,939,681	
	31 **Total liabilities and net assets/fund balances** (see instructions)	56,516,388	40,371,925	

Part III Analysis of Changes in Net Assets or Fund Balances

1	Total net assets or fund balances at beginning of year - Part II, column (a), line 30 (must agree with end-of-year figure reported on prior year's return)	1	45,907,590
2	Enter amount from Part I, line 27a	2	(12,968,017)
3	Other increases not included in line 2 (itemize) ▶ Prior Year Adjustment	3	108
4	Add lines 1, 2, and 3	4	32,939,681
5	Decreases not included in line 2 (itemize) ▶	5	
6	Total net assets or fund balances at end of year (line 4 minus line 5) - Part II, column (b), line 30	6	32,939,681

Part IV Capital Gains and Losses for Tax on Investment Income

	(a) List and describe the kind(s) of property sold (e g , real estate, 2-story brick warehouse, or common stock, 200 shs MLC Co)	(b) How acquired P - Purchase D - Donation	(c) Date acquired (mo , day, yr)	(d) Date sold (mo , day, yr)
1a				
b				
c				
d				
e				

	(e) Gross sales price	(f) Depreciation allowed (or allowable)	(g) Cost or other basis plus expense of sale	(h) Gain or (loss) (e) plus (f) minus (g)
a				0
b				0
c				0
d				0
e				0

	Complete only for assets showing gain in column (h) and owned by the foundation on 12/31/69			(l) Gains (Col (h) gain minus col (k), but not less than -0-) or Losses (from col (h))
	(i) F M V as of 12/31/69	(j) Adjusted basis as of 12/31/69	(k) Excess of col (i) over col (j), if any	
a			0	0
b			0	0
c			0	0
d			0	0
e			0	0

2	Capital gain net income or (net capital loss) { If gain, also enter in Part I, line 7 / If (loss), enter -0- in Part I, line 7 }	2	0
3	Net short-term capital gain or (loss) as defined in sections 1222(5) and (6): If gain, also enter in Part I, line 8, column (c) (see instructions). If (loss), enter -0- in Part I, line 8	3	N/A

Part V Qualification Under Section 4940(e) for Reduced Tax on Net Investment Income

(For optional use by domestic private foundations subject to the section 4940(a) tax on net investment income)

If section 4940(d)(2) applies, leave this part blank

Was the foundation liable for the section 4942 tax on the distributable amount of any year in the base period? ☐ Yes ☐ No
If "Yes," the foundation does not qualify under section 4940(e) Do not complete this part.

1 Enter the appropriate amount in each column for each year; see the instructions before making any entries.

(a) Base period years Calendar year (or tax year beginning in)	(b) Adjusted qualifying distributions	(c) Net value of noncharitable-use assets	(d) Distribution ratio (col (b) divided by col (c))
2013			0.0000
2012			0.0000
2011			0.0000
2010			0.0000
2009			0.0000

2	**Total** of line 1, column (d)	2	0.0000
3	Average distribution ratio for the 5-year base period - divide the total on line 2 by 5, or by the number of years the foundation has been in existence if less than 5 years	3	0.0000
4	Enter the net value of noncharitable-use assets for 2014 from Part X, line 5	4	0
5	Multiply line 4 by line 3	5	0
6	Enter 1% of net investment income (1% of Part I, line 27b)	6	0
7	Add lines 5 and 6	7	0
8	Enter qualifying distributions from Part XII, line 4	8	595,611,943

If line 8 is equal to or greater than line 7, check the box in Part VI, line 1b, and complete that part using a 1% tax rate See the Part VI instructions.

Part VI Excise Tax Based on Investment Income (Section 4940(a), 4940(b), 4940(e), or 4948 - see instructions)

1a	Exempt operating foundations described in section 4940(d)(2), check here ▶ ☐ and enter "N/A" on line 1. Date of ruling or determination letter _____ (attach copy of letter if necessary - see instructions)		
b	Domestic foundations that meet the section 4940(e) requirements in Part V, check here ▶ ☐ and enter 1% of Part I, line 27b	1	
c	All other domestic foundations enter 2% of line 27b Exempt foreign organizations enter 4% of Part I, line 12, col (b)		
2	Tax under section 511 (domestic section 4947(a)(1) trusts and taxable foundations only Others enter -0-)	2	
3	Add lines 1 and 2	3	0
4	Subtitle A (income) tax (domestic section 4947(a)(1) trusts and taxable foundations only Others enter -0-)	4	
5	**Tax based on investment income.** Subtract line 4 from line 3 If zero or less, enter -0-	5	0
6	Credits/Payments		
a	2014 estimated tax payments and 2013 overpayment credited to 2014 — 6a		
b	Exempt foreign organizations - tax withheld at source — 6b		
c	Tax paid with application for extension of time to file (Form 8868) — 6c		
d	Backup withholding erroneously withheld — 6d		
7	Total credits and payments Add lines 6a through 6d	7	0
8	Enter any **penalty** for underpayment of estimated tax Check here ☐ if Form 2220 is attached	8	
9	**Tax due.** If the total of lines 5 and 8 is more than line 7, enter **amount owed** ▶	9	0
10	**Overpayment.** If line 7 is more than the total of lines 5 and 8, enter the **amount overpaid** ▶	10	0
11	Enter the amount of line 10 to be **Credited to 2015 estimated tax** ▶ **Refunded** ▶	11	0

Part VII-A Statements Regarding Activities

			Yes	No
1a	During the tax year, did the foundation attempt to influence any national, state, or local legislation or did it participate or intervene in any political campaign?	1a		X
b	Did it spend more than $100 during the year (either directly or indirectly) for political purposes (see Instructions for the definition)?	1b		X
	*If the answer is "Yes" to **1a** or **1b**, attach a detailed description of the activities and copies of any materials published or distributed by the foundation in connection with the activities*			
c	Did the foundation file **Form 1120-POL** for this year?	1c		X
d	Enter the amount (if any) of tax on political expenditures (section 4955) imposed during the year (1) On the foundation ▶ $ _____ (2) On foundation managers ▶ $ _____			
e	Enter the reimbursement (if any) paid by the foundation during the year for political expenditure tax imposed on foundation managers ▶ $ _____			
2	Has the foundation engaged in any activities that have not previously been reported to the IRS? *If "Yes," attach a detailed description of the activities*	2		X
3	Has the foundation made any changes, not previously reported to the IRS, in its governing instrument, articles of incorporation, or bylaws, or other similar instruments? *If "Yes," attach a conformed copy of the changes*	3		X
4a	Did the foundation have unrelated business gross income of $1,000 or more during the year?	4a		X
b	If "Yes," has it filed a tax return on **Form 990-T** for this year?	4b	N	A
5	Was there a liquidation, termination, dissolution, or substantial contraction during the year? *If "Yes," attach the statement required by General Instruction T.*	5		X
6	Are the requirements of section 508(e) (relating to sections 4941 through 4945) satisfied either. • By language in the governing instrument, or • By state legislation that effectively amends the governing instrument so that no mandatory directions that conflict with the state law remain in the governing instrument?	6	X	
7	Did the foundation have at least $5,000 in assets at any time during the year? *If "Yes," complete Part II, col (c), and Part XV*	7	X	
8a	Enter the states to which the foundation reports or with which it is registered (see instructions) ▶ California			
b	If the answer is "Yes" to line 7, has the foundation furnished a copy of Form 990-PF to the Attorney General (or designate) of each state as required by *General Instruction G? If "No," attach explanation*	8b	X	
9	Is the foundation claiming status as a private operating foundation within the meaning of section 4942(j)(3) or 4942(j)(5) for calendar year 2014 or the taxable year beginning in 2014 (see instructions for Part XIV)? *If "Yes," complete Part XIV*	9	X	
10	Did any persons become substantial contributors during the tax year? *If "Yes," attach a schedule listing their names and addresses*	10		X

Part VII-A Statements Regarding Activities *(continued)*

11	At any time during the year, did the foundation, directly or indirectly, own a controlled entity within the meaning of section 512(b)(13)? If "Yes," attach schedule (see instructions)	11		X
12	Did the foundation make a distribution to a donor advised fund over which the foundation or a disqualified person had advisory privileges? If "Yes," attach statement (see instructions)	12		X
13	Did the foundation comply with the public inspection requirements for its annual returns and exemption application?	13	X	

Website address ▶ http://www.genentech-access.com

14 The books are in care of ▶ Ruth Werner Telephone no ▶ (650) 467-6308

Located at ▶ 1 DNA Way, South San Francisco, Ca ZIP+4 ▶ 94080

15 Section 4947(a)(1) nonexempt charitable trusts filing Form 990-PF in lieu of **Form 1041** - Check here ▶ ☐

and enter the amount of tax-exempt interest received or accrued during the year ▶ 15

			Yes	No
16	At any time during calendar year 2014, did the foundation have an interest in or a signature or other authority over a bank, securities, or other financial account in a foreign country?	16		x

See the instructions for exceptions and filing requirements for FinCEN Form 114, (formerly TD F 90-22 1) If "Yes," enter the name of the foreign country ▶

Part VII-B Statements Regarding Activities for Which Form 4720 May Be Required

File Form 4720 if any item is checked in the "Yes" column, unless an exception applies.

			Yes	No
1a	During the year did the foundation (either directly or indirectly)			
	(1) Engage in the sale or exchange, or leasing of property with a disqualified person? ☐ Yes ☒ No			
	(2) Borrow money from, lend money to, or otherwise extend credit to (or accept it from) a disqualified person? ☐ Yes ☒ No			
	(3) Furnish goods, services, or facilities to (or accept them from) a disqualified person? ☐ Yes ☒ No			
	(4) Pay compensation to, or pay or reimburse the expenses of, a disqualified person? ☐ Yes ☒ No			
	(5) Transfer any income or assets to a disqualified person (or make any of either available for the benefit or use of a disqualified person)? ☐ Yes ☒ No			
	(6) Agree to pay money or property to a government official? (**Exception.** Check "No" if the foundation agreed to make a grant to or to employ the official for a period after termination of government service, if terminating within 90 days) ☐ Yes ☒ No			
b	If any answer is "Yes" to 1a(1)-(6), did **any** of the acts fail to qualify under the exceptions described in Regulations section 53 4941(d)-3 or in a current notice regarding disaster assistance (see instructions)?	1b	N	A
	Organizations relying on a current notice regarding disaster assistance check here ▶ ☐			
c	Did the foundation engage in a prior year in any of the acts described in 1a, other than excepted acts, that were not corrected before the first day of the tax year beginning in 2014?	1c		X
2	Taxes on failure to distribute income (section 4942) (does not apply for years the foundation was a private operating foundation defined in section 4942(j)(3) or 4942(j)(5))			
a	At the end of tax year 2014, did the foundation have any undistributed income (lines 6d and 6e, Part XIII) for tax year(s) beginning before 2014? ☐ Yes ☒ No			
	If "Yes," list the years ▶ _____, _____, _____, _____			
b	Are there any years listed in 2a for which the foundation is **not** applying the provisions of section 4942(a)(2) (relating to incorrect valuation of assets) to the year's undistributed income? (If applying section 4942(a)(2) to **all** years listed, answer "No" and attach statement - see instructions)	2b	N	A
c	If the provisions of section 4942(a)(2) are being applied to **any** of the years listed in 2a, list the years here ▶ _____, _____, _____, _____			
3a	Did the foundation hold more than a 2% direct or indirect interest in any business enterprise at any time during the year? ☐ Yes ☒ No			
b	If "Yes," did it have excess business holdings in 2014 as a result of **(1)** any purchase by the foundation or disqualified persons after May 26, 1969, **(2)** the lapse of the 5-year period (or longer period approved by the Commissioner under section 4943(c)(7)) to dispose of holdings acquired by gift or bequest, or **(3)** the lapse of the 10-, 15-, or 20-year first phase holding period? *(Use Schedule C, Form 4720, to determine if the foundation had excess business holdings in 2014)*	3b	N	A
4a	Did the foundation invest during the year any amount in a manner that would jeopardize its charitable purposes?	4a		X
b	Did the foundation make any investment in a prior year (but after December 31, 1969) that could jeopardize its charitable purpose that had not been removed from jeopardy before the first day of the tax year beginning in 2014?	4b		X

Part VII-B Statements Regarding Activities for Which Form 4720 May Be Required *(continued)*

5a	During the year did the foundation pay or incur any amount to			
	(1) Carry on propaganda, or otherwise attempt to influence legislation (section 4945(e))? ☐ Yes ☒ No			
	(2) Influence the outcome of any specific public election (see section 4955), or to carry on, directly or indirectly, any voter registration drive? ☐ Yes ☒ No			
	(3) Provide a grant to an individual for travel, study, or other similar purposes? ☐ Yes ☒ No			
	(4) Provide a grant to an organization other than a charitable, etc , organization described in section 4945(d)(4)(A)? (see instructions) ☐ Yes ☒ No			
	(5) Provide for any purpose other than religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals? ☐ Yes ☒ No			
b	If any answer is "Yes" to 5a(1)-(5), did **any** of the transactions fail to qualify under the exceptions described in Regulations section 53 4945 or in a current notice regarding disaster assistance (see instructions)?	5b	N	A
	Organizations relying on a current notice regarding disaster assistance check here ▶ ☐			
c	If the answer is "Yes" to question 5a(4), does the foundation claim exemption from the tax because it maintained expenditure responsibility for the grant? ☐ Yes ☐ No			
	If "Yes," attach the statement required by Regulations section 53 4945-5(d)			
6a	Did the foundation, during the year, receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? ☐ Yes ☒ No			
b	Did the foundation, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	6b		X
	If "Yes" to 6b, file Form 8870			
7a	At any time during the tax year, was the foundation a party to a prohibited tax shelter transaction? ☐ Yes ☒ No			
b	If "Yes," did the foundation receive any proceeds or have any net income attributable to the transaction?	7b	N	A

Part VIII Information About Officers, Directors, Trustees, Foundation Managers, Highly Paid Employees, and Contractors

1 List all officers, directors, trustees, foundation managers and their compensation (see instructions).

(a) Name and address	(b) Title, and average hours per week devoted to position	(c) Compensation (If not paid, enter -0-)	(d) Contributions to employee benefit plans and deferred compensation	(e) Expense account, other allowances
See Schedule #1 Attached.				

2 Compensation of five highest-paid employees (other than those included on line 1 - see instructions). If none, enter "NONE."

(a) Name and address of each employee paid more than $50,000	(b) Title, and average hours per week devoted to position	(c) Compensation	(d) Contributions to employee benefit plans and deferred compensation	(e) Expense account, other allowances
NONE				

Total number of other employees paid over $50,000 ▶

Part VIII **Information About Officers, Directors, Trustees, Foundation Managers, Highly Paid Employees, and Contractors** *(continued)*

3 Five highest-paid independent contractors for professional services (see instructions). If none, enter "NONE."

(a) Name and address of each person paid more than $50,000	(b) Type of service	(c) Compensation
NONE		
Total number of others receiving over $50,000 for professional services ▶		

Part IX-A **Summary of Direct Charitable Activities**

List the foundation's four largest direct charitable activities during the tax year Include relevant statistical information such as the number of organizations and other beneficiaries served, conferences convened, research papers produced, etc	Expenses
1 Distribution of pharmaceutical products to eligible uninsured or underinsured patients in the United States. During 2014, the Genentech Access to Care Foundation provided approximately $583 million worth of prescription drugs to patients.	
2	
3	
4	

Part IX-B **Summary of Program-Related Investments** (see instructions)

Describe the two largest program-related investments made by the foundation during the tax year on lines 1 and 2	Amount
1 NONE	
2	
All other program-related investments See instructions	
3	
Total. Add lines 1 through 3 ▶	0

Part X Minimum Investment Return (All domestic foundations must complete this part. Foreign foundations, see instructions.)

1	Fair market value of assets not used (or held for use) directly in carrying out charitable, etc , purposes.		
a	Average monthly fair market value of securities	1a	0
b	Average of monthly cash balances	1b	
c	Fair market value of all other assets (see instructions)	1c	
d	**Total** (add lines 1a, b, and c)	1d	0
e	Reduction claimed for blockage or other factors reported on lines 1a and 1c (attach detailed explanation) 1e		
2	Acquisition indebtedness applicable to line 1 assets	2	
3	Subtract line 2 from line 1d	3	0
4	Cash deemed held for charitable activities Enter 1 1/2% of line 3 (for greater amount, see instructions)	4	0
5	**Net value of noncharitable-use assets.** Subtract line 4 from line 3 Enter here and on Part V, line 4	5	0
6	**Minimum investment return.** Enter 5% of line 5	6	0

Part XI Distributable Amount (see instructions) (Section 4942(j)(3) and (j)(5) private operating foundations and certain foreign organizations check here ▶ [X] and do not complete this part)

1	Minimum investment return from Part X, line 6			1	0
2a	Tax on investment income for 2014 from Part VI, line 5	2a	0		
b	Income tax for 2014. (This does not include the tax from Part VI.)	2b			
c	Add lines 2a and 2b			2c	0
3	Distributable amount before adjustments. Subtract line 2c from line 1			3	0
4	Recoveries of amounts treated as qualifying distributions			4	
5	Add lines 3 and 4			5	0
6	Deduction from distributable amount (see instructions)			6	
7	**Distributable amount** as adjusted Subtract line 6 from line 5. Enter here and on Part XIII, line 1			7	0

Part XII Qualifying Distributions (see instructions)

1	Amounts paid (including administrative expenses) to accomplish charitable, etc , purposes.		
a	Expenses, contributions, gifts, etc - total from Part I, column (d), line 26	1a	595,611,943
b	Program-related investments - total from Part IX-B	1b	0
2	Amounts paid to acquire assets used (or held for use) directly in carrying out charitable, etc., purposes	2	
3	Amounts set aside for specific charitable projects that satisfy the.		
a	Suitability test (prior IRS approval required)	3a	
b	Cash distribution test (attach the required schedule)	3b	
4	**Qualifying distributions.** Add lines 1a through 3b Enter here and on Part V, line 8, and Part XIII, line 4	4	595,611,943
5	Foundations that qualify under section 4940(e) for the reduced rate of tax on net investment income Enter 1% of Part I, line 27b (see instructions)	5	
6	**Adjusted qualifying distributions.** Subtract line 5 from line 4	6	595,611,943

Note. The amount on line 6 will be used in Part V, column (b), in subsequent years when calculating whether the foundation qualifies for the section 4940(e) reduction of tax in those years

Part XIII Undistributed Income (see instructions)

	(a) Corpus	(b) Years prior to 2013	(c) 2013	(d) 2014
1 Distributable amount for 2014 from Part XI, line 7				0
2 Undistributed income, if any, as of the end of 2014				
a Enter amount for 2013 only				
b Total for prior years 20_____,20_____,20_____				
3 Excess distributions carryover, if any, to 2014				
a From 2009				
b From 2010				
c From 2011				
d From 2012				
e From 2013				
f **Total** of lines 3a through e	0			
4 Qualifying distributions for 2014 from Part XII, line 4 ▶ $ 595,611,943				
a Applied to 2013, but not more than line 2a				
b Applied to undistributed income of prior years (Election required - see instructions)				
c Treated as distributions out of corpus (Election required - see instructions)				
d Applied to 2014 distributable amount				
e Remaining amount distributed out of corpus				
5 Excess distributions carryover applied to 2014 *(If an amount appears in column (d), the same amount must be shown in column (a).)*				
6 **Enter the net total of each column as indicated below:**				
a Corpus Add lines 3f, 4c, and 4e Subtract line 5	0			
b Prior years' undistributed income Subtract line 4b from line 2b		0		
c Enter the amount of prior years' undistributed income for which a notice of deficiency has been issued, or on which the section 4942(a) tax has been previously assessed				
d Subtract line 6c from line 6b Taxable amount - see instructions		0		
e Undistributed income for 2013. Subtract line 4a from line 2a Taxable amount - see instructions			0	
f Undistributed income for 2014 Subtract lines 4d and 5 from line 1 This amount must be distributed in 2015				0
7 Amounts treated as distributions out of corpus to satisfy requirements imposed by section 170(b)(1)(F) or 4942(g)(3) (Election may be required - see instructions)				
8 Excess distributions carryover from 2009 not applied on line 5 or line 7 (see instructions)				
9 **Excess distributions carryover to 2015.** Subtract lines 7 and 8 from line 6a	0			
10 Analysis of line 9				
a Excess from 2010				
b Excess from 2011				
c Excess from 2012				
d Excess from 2013				
e Excess from 2014				

Part XIV Private Operating Foundations (see instructions and Part VII-A, question 9)

1a If the foundation has received a ruling or determination letter that it is a private operating foundation, and the ruling is effective for 2014, enter the date of the ruling . . . . . ▶

b Check box to indicate whether the foundation is a private operating foundation described in section ☐ 4942(j)(3) or ☐ 4942(j)(5)

	Tax year	Prior 3 years			(e) Total
2a Enter the lesser of the adjusted net income from Part I or the minimum investment return from Part X for each year listed	(a) 2014	(b) 2013	(c) 2012	(d) 2011	
	0	3	12	1,238	1,253
b 85% of line 2a	0	2	10	1,052	1,064
c Qualifying distributions from Part XII, line 4 for each year listed	595,611,943	703,696,268	690,746,654	579,501,968	2,569,556,833
d Amounts included in line 2c not used directly for active conduct of exempt activities					0
e Qualifying distributions made directly for active conduct of exempt activities Subtract line 2d from line 2c	595,611,943	703,696,268	690,746,654	579,501,968	2,569,556,833
3 Complete 3a, b, or c for the alternative test relied upon					
a "Assets" alternative test - enter (1) Value of all assets	40,371,925	56,516,388	62,512,918	59,788,925	219,190,156
(2) Value of assets qualifying under section 4942(j)(3)(B)(i)	40,371,925	56,516,388	62,512,918	59,788,925	219,190,156
b "Endowment" alternative test- enter 2/3 of minimum investment return shown in Part X, line 6 for each year listed					0
c "Support" alternative test - enter (1) Total support other than gross investment income (interest, dividends, rents, payments on securities loans (section 512(a)(5)), or royalties)					0
(2) Support from general public and 5 or more exempt organizations as provided in section 4942 (j)(3)(B)(iii)					0
(3) Largest amount of support from an exempt organization					0
(4) Gross investment income					0

Part XV Supplementary Information (Complete this part only if the foundation had $5,000 or more in assets at any time during the year - see instructions.)

1 **Information Regarding Foundation Managers:**

a List any managers of the foundation who have contributed more than 2% of the total contributions received by the foundation before the close of any tax year (but only if they have contributed more than $5,000) (See section 507(d)(2))

NONE

b List any managers of the foundation who own 10% or more of the stock of a corporation (or an equally large portion of the ownership of a partnership or other entity) of which the foundation has a 10% or greater interest

NONE

2 **Information Regarding Contribution, Grant, Gift, Loan, Scholarship, etc., Programs:**

Check here ▶ ☐ if the foundation only makes contributions to preselected charitable organizations and does not accept unsolicited requests for funds If the foundation makes gifts, grants, etc. (see instructions) to individuals or organizations under other conditions, complete items 2a, b, c, and d.

a The name, address, and telephone number or e-mail address of the person to whom applications should be addressed

Genentech Access to Care Foundation, 1 DNA Way, MS #858A, South San Fracisco, CA 94080

b The form in which applications should be submitted and information and materials they should include·

See Schedule #2 Attached.

c Any submission deadlines:

See Schedule #2 Attached.

d Any restrictions or limitations on awards, such as by geographical areas, charitable fields, kinds of institutions, or other factors:

See Schedule #2 Attached.

Part XV Supplementary Information (continued)

3 Grants and Contributions Paid During the Year or Approved for Future Payment

Recipient Name and address (home or business)	If recipient is an individual, show any relationship to any foundation manager or substantial contributor	Foundation status of recipient	Purpose of grant or contribution	Amount
a *Paid during the year*				
All recipients are individual patients. See Schedule #2 attached.	No relationships	N/A	Provide prescription drugs	575,174,762
Total ▶ **3a**				575,174,762
b *Approved for future payment*				
All recipients are individual patients. See Schedule #2 attached.	No relationships	N/A	Provide prescription drugs	7,432,244
Total ▶ **3b**				7,432,244

Part XVI-A Analysis of Income-Producing Activities

Enter gross amounts unless otherwise indicated	Unrelated business income		Excluded by section 512, 513, or 514		(e) Related or exempt function income (See instructions)
	(a) Business code	(b) Amount	(c) Exclusion code	(d) Amount	
1 Program service revenue					
a					
b					
c					
d					
e					
f					
g Fees and contracts from government agencies					
2 Membership dues and assessments					
3 Interest on savings and temporary cash investments					
4 Dividends and interest from securities					
5 Net rental income or (loss) from real estate					
a Debt-financed property					
b Not debt-financed property					
6 Net rental income or (loss) from personal property					
7 Other investment income					
8 Gain or (loss) from sales of assets other than inventory					
9 Net income or (loss) from special events					
10 Gross profit or (loss) from sales of inventory					
11 Other revenue a					
b					
c					
d					
e					
12 Subtotal Add columns (b), (d), and (e)		0		0	0
13 **Total.** Add line 12, columns (b), (d), and (e)				13	0

(See worksheet in line 13 instructions to verify calculations)

Part XVI-B Relationship of Activities to the Accomplishment of Exempt Purposes

Line No. ▼	Explain below how each activity for which income is reported in column (e) of Part XVI-A contributed importantly to the accomplishment of the foundation's exempt purposes (other than by providing funds for such purposes). (See instructions.)
	N/A

Part XVII Information Regarding Transfers To and Transactions and Relationships With Noncharitable Exempt Organizations

			Yes	No
1	Did the organization directly or indirectly engage in any of the following with any other organization described in section 501(c) of the Code (other than section 501(c)(3) organizations) or in section 527, relating to political organizations?			
a	Transfers from the reporting foundation to a noncharitable exempt organization of:			
	(1) Cash	1a(1)		X
	(2) Other assets	1a(2)		X
b	Other transactions:			
	(1) Sales of assets to a noncharitable exempt organization	1b(1)		X
	(2) Purchases of assets from a noncharitable exempt organization	1b(2)		X
	(3) Rental of facilities, equipment, or other assets	1b(3)		X
	(4) Reimbursement arrangements	1b(4)		X
	(5) Loans or loan guarantees	1b(5)		X
	(6) Performance of services or membership or fundraising solicitations	1b(6)		X
c	Sharing of facilities, equipment, mailing lists, other assets, or paid employees	1c		X

d If the answer to any of the above is "Yes," complete the following schedule. Column (b) should always show the fair market value of the goods, other assets, or services given by the reporting foundation. If the foundation received less than fair market value in any transaction or sharing arrangement, show in column (d) the value of the goods, other assets, or services received.

(a) Line no	(b) Amount involved	(c) Name of noncharitable exempt organization	(d) Description of transfers, transactions, and sharing arrangements

2a Is the foundation directly or indirectly affiliated with, or related to, one or more tax-exempt organizations described in section 501(c) of the Code (other than section 501(c)(3)) or in section 527? ☐ Yes ☐ No

b If "Yes," complete the following schedule.

(a) Name of organization	(b) Type of organization	(c) Description of relationship

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge

Sign Here

▶ [signature] | 6/8/15 | ▶ CFO

Signature of officer or trustee | Date | Title

May the IRS discuss this return with the preparer shown below (see instructions)? ☐ Yes ☐ No

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN

Firm's name ▶ | Firm's EIN ▶

Firm's address ▶ | Phone no

Schedule B (Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ **Attach to Form 990, Form 990-EZ, or Form 990-PF.**
▶ **Information about Schedule B (Form 990, 990-EZ, or 990-PF) and its instructions is at *www.irs.gov/form990.***

OMB No 1545-0047

2014

Name of the organization	**Employer identification number**
Genentech Access to Care Foundation	46-0500266

Organization type (check one)

Filers of:	**Section:**
Form 990 or 990-EZ	☐ 501(c)( ) (enter number) organization
	☐ 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	☐ 527 political organization
Form 990-PF	☒ 501(c)(3) exempt private foundation
	☐ 4947(a)(1) nonexempt charitable trust treated as a private foundation
	☐ 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions

General Rule

☒ For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling $5,000 or more (in money or property) from any one contributor Complete Parts I and II See instructions for determining a contributor's total contributions.

Special Rules

☐ For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3 % support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of **(1)** $5,000 or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1 Complete Parts I and II

☐ For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.

☐ For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc , purposes, but no such contributions totaled more than $1,000 If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc , purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling $5,000 or more during the year . . . . . ▶ $ _____

Caution. An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization	Employer identification number
Genentech Access to Care Foundation	46-0500266

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	Genentech, Inc. 1 DNA Way, MS #24 South San Francisco, CA 94080	$ 590,076,170	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions)

Name of organization	Employer identification number
Genentech Access to Care Foundation	46-0500266

Part II **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
1	Pharmaceutical Products -- $569,638,989 Shipping & Handling Expenses -- $5,217,805 General & Administrative Exps -- $15,219,376	$ 590,076,170	1/1/14-12/31/14
		$	
		$	
		$	
		$	
		$	

Name of organization	Employer identification number
Genentech Access to Care Foundation	46-0500266

Part III ***Exclusively*** **religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than $1,000 for the year from any one contributor.** Complete columns **(a)** through **(e) and** the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **$1,000 or less** for the year. (Enter this information once. See instructions.) ▶ $ ____________
Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
----			

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
----			

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
----			

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
----			

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

GENENTECH ACCESS TO CARE FOUNDATION **EIN: 46-0500266**
Form 990-PF **Tax Year 2014**

Attachment to Form 990-PF **Schedule # 1**

Form 990-PF, Part I, Item 23

Shipping & Handling Expenses	$ 5,217,805
General & Administrative Expenses	15,219,376
Total Other Expenses	$ 20,437,181

Form 990-PF, Part VII-A, Item 10

Genentech, Inc., 1 DNA Way, South San Francisco, CA 94080, was the sole contributor to the ATC Foundation. As a substantial contributor, Genentech, Inc. is a disqualified person with respect to the Foundation.

Form 990-PF, Part VIII, Item 1

1.a. Officers and Trustees	**1.b.** Title and Hours/week
Officers	
Steve Krognes 1 DNA Way, So San Francisco, CA 94080	President 1 hr/wk
Jane Machin (Resigned 12-2-2014) 1 DNA Way, So. San Francisco, CA 94080	CFO 3 hrs/wk
Ruth Werner (Appointed 12-2-2014) 1 DNA Way, So. San Francisco, CA 94080	CFO 3 hrs/wk
Renee Shiota 1 DNA Way, So San Francisco, CA 94080	Secretary 30 hrs/wk
Neela Paykel 1 DNA Way, So. San Francisco, CA 94080	General Counsel 5 hrs/wk
Trustees	
Alexander Hardy (Resigned 4-13-2014)	1 hr/wk
Sandra Horning (Resigned 5-22-2014)	1 hrs/wk
Sean Johnston	1 hr/wk
Mary Sliwkowski	1 hr/wk
Geoff Teeter	1 hr/wk
Evan Morris (Appointed 5-23-2014)	1 hr/wk
Ann Lee-Karlon (Appointed 5-23-2014)	1 hr/wk
Dietmar Berger (Appointed 12-2-2014)	1 hr/wk

All trustees may be reached at 1 DNA Way, South San Francisco, CA 94080.

1.c. Officers and Trustees of the Foundation are not compensated for their services. The officers and trustees are employees of, and are compensated solely by, Genentech, Inc. or Genentech USA, Inc.

1.d. Officers and Trustee have no benefits provided by the Foundation.

1.e. Officers and Trustees have no expense accounts or other allowances.

GENENTECH ACCESS TO CARE FOUNDATION **EIN: 46-0500266**
Form 990-PF **Tax Year 2014**

Attachment to Form 990-PF **Schedule # 2**

Form 990-PF, Part XV, Items 2 and 3

2. **b., c., d.** The Genentech Access To Care Foundation (the "Foundation") operates a patient drug assistance program that provides pharmaceutical products manufactured by Genentech, Inc to uninsured, underinsured or indigent patients (the "Program")

   Under the Program, patients who have been diagnosed with certain medical conditions and who cannot afford a program of prolonged medication may apply to the Foundation for assistance. The application requires medical information from the patient's physician as well as financial information from the patient. Patient eligibility is determined by evaluating all relevant facts including a diagnosis within approved product application, household income, insurance, third-party and/or government reimbursement, cost of medications and any extenuating circumstances. See sample form attached

   When the application for assistance is approved, the patient receives the pharmaceutical products free of charge. After acceptance, patient eligibility is reviewed periodically and the patient continues to receive products free of charge as long as eligibility requirements are met.

   All drugs provided by the Foundation are approved by the U.S. Food and Drug Administration and are sold in compliance with applicable laws. Products provided include, but are not limited to: Tarceva, Lucentis, Herceptin, Rituxan , TNKase, Cathflo Activase, Pulmozyme, Nutropin, Nutropin AQ, Avastin, Xolair, Actemra, Boniva, Cellcept, Copegus, Erivedge, Fuzeon, Invirase, Pegasys, Perjeta, Valcyte, Xeloda, Kadcyla, Gazyva, and Zelboraf.

3. **a., b.** Recipients are individual patients who have applied to the Foundation and are eligible to receive the approved drugs. The Foundation has a commitment to maintain a certain level of confidentiality for each recipient Specific details are available upon request by the Internal Revenue Service.

Genentech® Access to Care Foundation (GATCF)
Insurance Attestation – HCP Administered Drugs

Phone (866) 681-3329 - Fax (866) 681-3338

This form is required for each of your patient's insurances and will serve as proof that the patient's insurance company will not cover the prescribed ACTEMRA® (tocilizumab) therapy. This form should be completed once you have the outcome of the first level of appeal.

Check ALL box(es) that apply to your patient and fax to GATCF at the number listed above.

- ☐ My office received a first-level appeal denial and the initial claim or Prior Authorization (PA) denial is upheld.
  - Date of initial claim or PA denial: ____/____/____
  - Reason for initial claim or PA denial:_____
  - Date of first-level appeal denial: ____/____/____
  - Reason for first-level appeal denial:_____
- ☐ My office received a recoupment for date of service:____/____/____
  - Date of recoupment letter:____/____/____
  - Reason for recoupment:_____
- ☐ My office received a peer-to-peer denial.
  - Date of review:____/____/____
  - Reason denial:_____
- ☐ My patient has met the daily/yearly CAP for insurance coverage.
  - Date CAP was met:____/____/____
  - Date CAP reset:____/____/____

PLEASE NOTE: *If the patient's insurance denied coverage due to an administrative error, untimely filing or not following the insurance policy requirements, your patient does not meet GATCF insurance criteria. GATCF requires one level of appeal for patients to be considered rendered uninsured.*

Please complete, sign and date the following statement. (REQUIRED)

Authorized HCP Signature (Required): _____Date:_____

Print Physician First and Last Name: _____

Patient Insurance Company Name: _____

Print Patient's First and Last Name: _____

Patient's Date of Birth: _____

CERTIFICATION: By signing above, I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements.

I know GATCF could ask me for a copy of the patient's insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

Genentech
A Member of the Roche Group

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Genentech® Access to Care Foundation (GATCF)
Confirmation of Infusion or Injection

Phone (800) 704-6614 - Fax (800) 704-6615

This completed document is required to participate in the Genentech Access to Care Foundation (GATCF) free Cathflo® Activase® (alteplase) program. This form is available online via My Patient Solutions™ for applicable brands*. Link to My Patient Solutions directly from http://www.cathflo.com/reimbursement/billing.jsp to enroll and manage your patients online.

Instructions: *All fields required.* Complete this form after each infusion/injection and fax completed form to GATCF at the number listed above or submit through My Patient Solutions.

Date of Service:	Amount Infused/Injected:	Date of Service:	Amount Infused/Injected:
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg

Please complete, sign and date the following statement. (REQUIRED)

Print Patient Name (Required): _____

Patient's Date of Birth (Required): _____

Authorized HCP Signature (Required)†: _____

Date of Signature (Required): _____

Next Scheduled Infusion (if applicable): _____

CERTIFICATION: By signing above, I certify that all information on this form is correct, and this patient has been infused/injected with product listed above. I know that GATCF could ask me for a copy of the patient's infusion/injection records for the purpose of an audit. I agree to provide a copy of the patient's infusion/injection records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the Confirmation of Infusion or Injection is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*Only BioOncology products, Rheumatology products and XOLAIR are supported by My Patient Solutions

†The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP)

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Genentech® Access to Care Foundation (GATCF)
Confirmation of Infusion or Injection

Phone (800) 530-3083 - Fax (650) 225-1366

This completed document is required to participate in the Genentech Access to Care Foundation (GATCF) free Activase® (alteplase) program. This form is available online via My Patient Solutions™ for applicable brands*. Link to My Patient Solutions directly from Genentech-Access.com to enroll and manage your patients online.

Instructions: *All fields required.* Complete this form after each infusion/injection and fax completed form to GATCF at the number listed above or submit through My Patient Solutions.

Date of Service:	Amount Infused/Injected:	Date of Service:	Amount Infused/Injected:
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg

Please complete, sign and date the following statement. (REQUIRED)

Print Patient Name (Required): _____

Patient's Date of Birth (Required): _____

Authorized HCP Signature (Required)†: _____

Date of Signature (Required): _____

Next Scheduled Infusion (if applicable): _____

CERTIFICATION: By signing above, I certify that all information on this form is correct, and this patient has been infused/injected with product listed above. I know that GATCF could ask me for a copy of the patient's infusion/injection records for the purpose of an audit. I agree to provide a copy of the patient's infusion/injection records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the Confirmation of Infusion or Injection is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*Only BioOncology products, Rheumatology products and XOLAIR are supported by My Patient Solutions.

†The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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AS.GEN.SOP.007.JBA.001
Current SMN & PAN Versions

Product	SMN Version	PAN Version	Spanish PAN Version
BioOncology (Infused)	ACS0001158202	ACS0929140044 ACS0000147504*	ACS0918140025(1) ACS0000276302*
BioOncology (Oral)	ACS0001158301 HED0001875400	ACS0929140043 ACS0001204901*	ACS0918140026(1) ACS0002177000*
Lucentis	LUC0001630600	ACS0929140046 ACS0001018304*	ACS0918140027(1) LUC0001611300*
Lytics	CAT0000597301	ACS0929140047 CAT0000735100*	ACS0918140035(1) CAT0000859100*
Pegasys	ACS0001005001	ACS0929140048 ACS0000441002*	ACS0918140029(1) PEG0000556300*
Pulmozyme	PUL00000654701	ACS0929140052 PUL00000654501*	ACS0918140030(1) PUL0000828500*
Rheumatology	ACS0000367903 ACS0002408300	ACS0929140049 ACS0002408300* ACS0000368103*	ACS0918140031(1) ACS0002241900*
Xolair	XOL0002290501 XOL1023140094(1) XOL0002337000*	ACS0929140051 XOL1023140094(1) XOL0002337000* XOL0001086801*	ACS0918140034(1) XOL0001270100*

* Accepted until 4/26/2015

Genentech® Access to Care Foundation (GATCF)
Confirmation of Infusion or Injection

Phone (800) 530-3083 - Fax (877) 428-2326

This completed document is required to participate in the Genentech Access to Care Foundation (GATCF) free Avastin® (bevacizumab) program. This form is available online via My Patient Solutions™ for applicable brands*. Link to My Patient Solutions directly from Genentech-Access.com/Avastin to enroll and manage your patients online.

Instructions: *All fields required.* Complete this form after each infusion/injection and fax completed form to GATCF at the number listed above or submit through My Patient Solutions.

Date of Service:	Amount Infused/Injected:	Date of Service:	Amount Infused/Injected:
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg

Please complete, sign and date the following statement. (REQUIRED)

Print Patient Name (Required): _____

Patient's Date of Birth (Required): _____

Authorized HCP Signature (Required)†: _____

Date of Signature (Required): _____

Next Scheduled Infusion (if applicable): _____

CERTIFICATION: By signing above, I certify that all information on this form is correct, and this patient has been infused/injected with product listed above. I know that GATCF could ask me for a copy of the patient's infusion/injection records for the purpose of an audit. I agree to provide a copy of the patient's infusion/injection records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the Confirmation of Infusion or Injection is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*Only BioOncology products, Rheumatology products and XOLAIR are supported by My Patient Solutions.

†The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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Genentech® Access to Care Foundation (GATCF)
Insurance Attestation – HCP Administered Drugs

Phone (800) 530-3083 - Fax (877) 428-2326

This form is required for each of your patient's insurances and will serve as proof that the patient's insurance company will not cover the prescribed Avastin® (bevacizumab) therapy. This form should be completed once you have the outcome of the first level of appeal.

Check ALL box(es) that apply to your patient and fax to GATCF at the number listed above.

- ❑ My office received a first-level appeal denial and the initial claim or Prior Authorization (PA) denial is upheld.
  - Date of initial claim or PA denial: ____/____/____
  - Reason for initial claim or PA denial:_____
  - Date of first-level appeal denial: ____/____/____
  - Reason for first-level appeal denial:_____
- ❑ My office received a recoupment for date of service:____/____/____
  - Date of recoupment letter:____/____/____
  - Reason for recoupment:_____
- ❑ My office received a peer-to-peer denial.
  - Date of review:____/____/____
  - Reason denial:_____
- ❑ My patient has met the daily/yearly CAP for insurance coverage.
  - Date CAP was met:____/____/____
  - Date CAP reset:____/____/____

PLEASE NOTE: *If the patient's insurance denied coverage due to an administrative error, untimely filing or not following the insurance policy requirements, your patient does not meet GATCF insurance criteria. GATCF requires one level of appeal for patients to be considered rendered uninsured.*

Please complete, sign and date the following statement. (REQUIRED)

Authorized HCP Signature (Required): _____Date:_____

Print Physician First and Last Name: _____

Patient Insurance Company Name: _____

Print Patient's First and Last Name: _____

Patient's Date of Birth: _____

CERTIFICATION: By signing above, I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements.

I know GATCF could ask me for a copy of the patient's insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION (PAN)

BIO ONCOLOGY | Access Solutions

INFUSED PRODUCTS

Phone: (888) 249-4918 **Fax:** (888) 249-4919 **Genentech-Access.com/BioOncology**

ACS/092914/0044 10/14

Genentech BioOncology Access Solutions is a free program for you from Genentech.

We work to help you pay for your Genentech product. We can help in many different ways. We assist people who have a health care plan as well as those who don't.

If you don't have a health care plan, or your plan won't pay for your Genentech product(s), we might be able to help. If you meet certain financial and medical standards, we can supply free medicine. This is done through the Genentech® Access to Care Foundation (GATCF).

For us to help, we need to look at, use and disclose your personally identifiable information (PII). Your health care provider and health care plan can disclose your PII to us only with your written authorization. By signing this authorization form, you are authorizing your health care provider and health care plan to release your PII to us, and authorizing us to disclose your PII as necessary to perform services for you. Once you sign this form and it is sent back to us, or submitted electronically by you or by your health care provider on your behalf, we can start to provide these services. You can choose not to agree to this authorization, however, please note that we cannot provide our services without it. This means you might need to pay for certain medications on your own.

PLEASE READ THROUGH THIS FORM CAREFULLY. IF YOU HAVE ANY QUESTIONS, TALK TO YOUR HEALTH CARE PROVIDER'S OFFICE OR CALL US AT THE PHONE NUMBER LISTED AT THE TOP OF THIS PAGE.

1 INFORMATION TO BE DISCLOSED OR USED

This signed form lets my health care providers and health care plans send my PII, and this form electronically, to Genentech Access Solutions and/or GATCF. This includes:

- All my health records relating to my treatment
- Information about my health care plan benefits
- The dollar balance left on the total of the lifetime payments covered by my health care plan policy (if this applies to my plan)
- Any information having a bearing on my health or my adherence to my treatment

All of the above is considered part of my PII. I know this could include information about:

- Sexually transmitted diseases
- Mental health conditions
- Genetic test results

2 WHO MAY SEE AND USE MY PII

My PII may be seen by Genentech Access Solutions and/or GATCF. These are programs sponsored by Genentech. Its address is 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. It may also be seen by anyone helping Genentech Access Solutions perform services, including Genentech employees and any of Genentech's partners, for the purpose of facilitating access to Genentech products. Genentech may share your PII with Sponsors, and/or their agents and affiliates, and your health care provider and health plan.

My PII may be used only in these ways:

- Helping with my health care plan coverage for Genentech products
- Applying to GATCF
- Determining eligibility for alternative forms of coverage and sources of funding
- Coordination of prescription fulfillment through a pharmacy
- Tracking my use of Genentech products
- For Genentech, or our partners' administrative purposes

3 NOTICES

This authorization and notice of release is in effect for 1 year from the date I signed it.

Once I sign this form, I know my PII might not be covered by any federal law that restricts the use and disclosure of my PII. There is no guarantee my PII might not be released to a third party. This third party might not need to follow the conditions of this authorization and notice of release.

I know I can refuse to sign this form. I may withdraw authorization at any time and for any reason. This won't affect the start or continuing of my treatment, the quality of my treatment, and will have no impact on my treatment by my health care provider. To withdraw it, I must send a written notice to Genentech. It can be sent by fax or by mail to the address on this page. This withdrawal goes into effect once it is received by Genentech. If I don't sign this form or if I withdraw my authorization, Genentech will not be able to help me with access to my Genentech product(s).

I understand that I, as the patient or signer, have a right to obtain a copy of this signed authorization and notice of release during the one year it is valid, and up to three years after it is signed.

4 DISTRIBUTION ACCEPTANCE

If I receive free product from GATCF, I will use Genentech products as my health care provider has prescribed them to me. I will not sell or distribute Genentech products. I understand it is unlawful to do this. I am responsible for ensuring any Genentech product is sent to a secure address when it is shipped to me. I know it is my duty to control any Genentech product while it stays in my possession.

This written notice must be signed, dated, and mailed, faxed, or electronically submitted to

Genentech Access Solutions
1 DNA Way, Mail Stop #858a
South San Francisco, CA 94080-4990

Fax: (888) 249-4919

5 SIGNATURE AND DATE (REQUIRED)

I have read this document or have had it explained to me. By signing this form, I know I am authorizing the release and disclosure of my PII as discussed in this authorization form. **Please fill in all information below. Be sure to sign and date this form. If you don't, it could hold up the process for helping you.**

You must sign and date here

_____ Signature of Patient or Legally Authorized Person

_____ Relationship to Patient

_____ Date Signed

You must print your name here

_____ Print Patient's Name

_____ Patient/Alternate Contact Address

If signing for the patient you must print your name here

_____ Legally Authorized Person/Alternate Contact Name

_____ Contact Phone

☐ OK to leave a detailed message*: I authorize Genentech Access Solutions/GATCF to leave a detailed message at the following number: _____

*I understand this message may include PII, including but not limited to, the name of the medication I have been prescribed, my doctor's name, and details regarding insurance coverage

6 FINANCIAL INFORMATION (GATCF ONLY)

TOTAL HOUSEHOLD INCOME FOR THE PREVIOUS CALENDAR YEAR: $ _____

Read the following attestation: I understand that to qualify for free medicine, GATCF has criteria that must be met, including income. I certify the above statement of my total annual household income for the previous calendar year is true, and I do not have the financial resources or insurance coverage to pay for Genentech products. I know that GATCF could ask me for a copy of my IRS 1040 form or other proof of income for the purpose of an audit. I agree to provide my financial documentation in a timely manner, if so requested. In addition, I will notify GATCF immediately if my insurance situation changes. Please note that GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the financial attestation is false or inaccurate. By signing this attestation, I certify that the above statement of my annual household income amount is true and accurate, to the best of my knowledge.

Sign and date here (Required for GATCF Enrollment)

_____ Signature of Patient or Legally Authorized Person

_____ Date Signed

7 AN OPTIONAL AND FREE PATIENT SUPPORT PROGRAM

I want to enroll in an optional and free patient support program from Genentech. I understand my PII is needed for me to be a part of this program. I also know my PII will be shared with Genentech Access Solutions and the patient support program. I may choose to be contacted by mail, email or phone. I understand my PII won't be shared outside of Genentech, or by its agents. I agree to let Genentech or its agents contact me in the future about this program.

The Genentech privacy policy can be found at Genentech-Access.com. I understand I do not have to sign this part of the form. It plays no role in getting my medicine. It is not part of receiving help from Genentech Access Solutions. I also know I may cancel this enrollment in the patient support program at any time. To cancel, I can call (877) 436-3683.

Preferred way to contact me (Please check the box that applies and fill in your information. You can check more than one box.):

☐ Email: _____ ☐ Phone Number: _____ Okay to leave a message? ☐ Yes ☐ No

☐ Address: _____

Choose to enroll by signing here

_____ Signature of Patient/Legally Authorized Person (You must sign here to enroll in the patient support program.)

_____ Date Signed

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AUTORIZACIÓN DEL PACIENTE Y AVISO DE DIVULGACIÓN DE INFORMACIÓN (PAN)

BIOONCOLOGY | Access Solutions

PRODUCTOS INFUNDIDOS

Teléfono: (888) 249-4918 **Fax:** (888) 249-4919 **Genentech-Access.com/BioOncology**

ACS/091814/0025(1) 10/14

Genentech BioOncology Access Solutions es un programa gratuito de Genentech para usted.

Trabajamos para ayudarlo a pagar su producto de Genentech. Podemos ayudarlo de muchas maneras diferentes. Ayudamos a las personas que cuentan con un plan de salud y a quienes no lo tienen.

Si no tiene plan de salud, o si su plan no pagará por su(s) producto(s) de Genentech, es posible que podamos ayudarlo. Si cumple con ciertos estándares financieros y médicos, podemos proporcionarle el medicamento en forma gratuita. Esto se hace a través de la Genentech® Access to Care Foundation (GATCF).

Para ayudarlo, necesitamos ver, usar y revelar su información personal identificable (personally identifiable information, PII). Su proveedor de atención médica y su plan de salud pueden revelarnos su PII únicamente con su autorización por escrito. Al firmar este formulario de autorización, usted autoriza a su proveedor de atención médica y a su plan de salud a entregarnos su PII, y nos autoriza a revelar su PII según sea necesario para proporcionarle servicios. Una vez que firme este formulario y este se nos envíe de regreso, o usted o su proveedor de atención médica en su nombre nos lo envíen electrónicamente, podemos empezar a proporcionarle estos servicios. Usted puede optar por no acceder a esta autorización, sin embargo, tenga en cuenta que no podemos proporcionarle nuestros servicios sin ella. Esto significa que podría ser necesario que pague ciertos medicamentos por su propia cuenta.

LEA CUIDADOSAMENTE ESTE FORMULARIO. SI TIENE PREGUNTAS, HABLE CON EL CONSULTORIO DE SU PROVEEDOR DE ATENCIÓN MÉDICA O LLÁMENOS AL NÚMERO TELEFÓNICO QUE APARECE EN LA PARTE SUPERIOR DE ESTA PÁGINA.

1 INFORMACIÓN QUE SE REVELARÁ O USARÁ

Este formulario firmado les permite a mis proveedores de atención médica y planes de salud enviar mi PII, y este formulario en forma electrónica, a Genentech Access Solutions y/o a la GATCF. Esto incluye:

- Todos mis registros médicos relacionados con mi tratamiento
- Información sobre los beneficios de mi plan de salud
- El saldo en dólares que queda del total de los pagos de por vida que cubre la póliza de mi plan de salud (si esto se aplica a mi plan)
- Toda información relacionada con mi salud o el cumplimiento de mi tratamiento

Todo lo mencionado arriba se considera parte de mi PII. Sé que esto podría incluir información sobre:

- Enfermedades de transmisión sexual
- Afecciones de salud mental
- Resultados de pruebas genéticas

2 QUIÉN PUEDE VER Y USAR MI PII

Mi PII puede ser vista por Genentech Access Solutions y/o la GATCF. Estos son programas que patrocina Genentech. Su dirección es 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. También puede ser vista por cualquier persona que ayude a Genentech Access Solutions en la prestación de servicios, lo que incluye a empleados de Genentech y a cualquier socio de Genentech, a los efectos de facilitar el acceso a los productos de Genentech. Genentech puede compartir su PII con los Patrocinadores, y/o sus agentes y afiliadas, y con su proveedor de atención médica y plan de salud.

Mi PII se puede usar solamente de las maneras siguientes:

- Ayudarme con la cobertura de mi plan de salud para productos de Genentech
- Presentar una solicitud a la GATCF
- Determinar la elegibilidad para formas de cobertura y fuentes de financiamiento alternativas
- Coordinación del surtido de recetas a través de una farmacia
- Rastrear mi uso de productos de Genentech
- Para fines administrativos de Genentech o de nuestros socios

3 AVISOS

Esta autorización y aviso de divulgación tiene vigencia durante 1 año a partir de la fecha en que la firmé.

Una vez que firme este formulario, sé que mi PII podría no estar cubierta por las leyes federales que restringen el uso y la divulgación de mi PII. No existe ninguna garantía de que mi PII no se revele a un tercero. Es posible que este tercero no necesite cumplir con las condiciones de esta autorización y aviso de divulgación.

Sé que puedo negarme a firmar este formulario. Puedo retirar la autorización en cualquier momento y por cualquier razón. Esto no afectará el inicio ni la continuación de mi tratamiento, tampoco afectará la calidad de mi tratamiento, ni tendrá efecto alguno en el tratamiento que me brinda mi proveedor de atención médica. Debo enviar un aviso por escrito a Genentech para retirarla. Puedo enviarlo por fax o por correo postal a la dirección que se muestra en esta página. Este retiro entra en vigencia una vez que Genentech lo recibe. Si no firmo este formulario o si retiro mi autorización, Genentech no podrá ayudarme con el acceso a mi(s) producto(s) de Genentech.

Comprendo que, como paciente o firmante, tengo derecho a obtener una copia de esta autorización y aviso de divulgación firmada durante el año en que tenga validez, y hasta tres años después de que se firme.

4 ACEPTACIÓN DE DISTRIBUCIÓN

Si recibo productos gratuitos de la GATCF, usaré los productos de Genentech como mi proveedor de atención médica me los recetó. No venderé o distribuiré los productos de Genentech. Entiendo que es ilegal hacerlo. Soy responsable de asegurarme de que cualquier producto de Genentech se envíe a una dirección segura cuando me hagan el envío. Sé que es mi deber controlar cualquier producto de Genentech mientras esté en mi poder.

Este aviso por escrito se debe firmar, fechar y enviar por correo postal, fax o en forma electrónica a:

Genentech Access Solutions
1 DNA Way, Mail Stop #858a
South San Francisco, CA 94080-4990

Fax: (888) 249-4919

5 FIRMA Y FECHA (OBLIGATORIAS)

He leído este documento o me lo han explicado. Al firmar este formulario, sé que estoy autorizando la divulgación y entrega de mi PII como se analiza en este formulario de autorización. **Complete toda la información a continuación. Asegúrese de firmar y fechar este formulario. Si no lo hace, se podría retrasar el proceso para brindarle ayuda.**

Debe firmar y colocar la fecha aquí _____ _____ _____
Firma del Paciente o de la Persona Legalmente Autorizada | Relación con el Paciente | Fecha de la Firma

Debe poner aquí su nombre, en letra de imprenta _____ _____
Nombre del Paciente, en Letra de Imprenta | Dirección del Paciente/Contacto Alternativo

Si firma por el paciente, debe poner aquí su nombre, en letra de imprenta _____ _____
Nombre de la Persona Legalmente Autorizada/Nombre del Contacto Alternativo | Teléfono del Contacto

☐ Se puede dejar un mensaje detallado*: Autorizo a Genentech Access Solutions/la GATCF a dejar un mensaje detallado en el siguiente número: _____

*Comprendo que este mensaje puede incluir PII, lo cual comprende, pero no se limita a, el nombre del medicamento que se me recetó, el nombre de mi médico y detalles relativos a la cobertura de seguro

6 INFORMACIÓN FINANCIERA (GATCF ÚNICAMENTE)

INGRESOS FAMILIARES TOTALES CORRESPONDIENTES AL AÑO CALENDARIO PREVIO: $ _____

Lea el testimonio siguiente: Comprendo que para reunir los requisitos a fin de recibir medicamentos gratuitos, la GATCF tiene ciertos criterios que se deben cumplir, lo que incluye los ingresos. Certifico que mi declaración anterior de los ingresos familiares totales correspondientes al año calendario previo es verdadera, y que no cuento con recursos económicos ni cobertura de seguro para pagar los productos de Genentech. Sé que la GATCF podría solicitarme una copia de mi formulario 1040 del IRS u otra prueba de mis ingresos para propósitos de auditoría. Estoy de acuerdo con proporcionar en forma oportuna mis documentos financieros, si me los solicitan. Además, notificaré inmediatamente a la GATCF si cambia mi situación de seguro. Tenga en cuenta que la GATCF ejercerá todos los recursos legales apropiados, lo que incluye un juicio de indemnización por daños y perjuicios en litigio, en el caso de que la GATCF determine que esta certificación es falsa o que el testimonio financiero es falso o inexacto. Al firmar este testimonio, certifico que el monto de mis ingresos familiares anuales declarados arriba es verdadero y exacto, a mi leal saber y entender.

Firme y coloque la fecha aquí (Se requiere para la inscripción en la GATCF) _____ _____
Firma del Paciente o de la Persona Legalmente Autorizada | Fecha de la Firma

7 UN PROGRAMA OPCIONAL Y GRATUITO DE ASISTENCIA AL PACIENTE

Deseo inscribirme en un programa opcional y gratuito de asistencia al paciente brindado por Genentech. Entiendo que se necesita mi PII para que pueda participar en este programa. También sé que se compartirá mi PII con Genentech Access Solutions y con el programa de asistencia al paciente. Puedo elegir que se me contacte por correo, correo electrónico o teléfono. Entiendo que mi PII no será compartida fuera de Genentech, ni por sus agentes. Acepto que Genentech o sus agentes se pongan en contacto conmigo en el futuro sobre este programa.

La política de privacidad de Genentech se puede encontrar en Genentech-Access.com. Entiendo que no tengo que firmar esta parte del formulario. No tiene ningún efecto a la hora de obtener mi medicamento. No forma parte de recibir asistencia de Genentech Access Solutions. También sé que puedo cancelar esta inscripción en el programa de asistencia al paciente en cualquier momento. Para cancelar, puedo llamar al (877) 436-3683.

Forma preferida de ponerse en contacto conmigo (Marque el casillero que corresponda y complete su información. Puede marcar más de un casillero.):

☐ Correo electrónico: _____ ☐ Número de teléfono: _____ ¿Se puede dejar un mensaje? ☐ Sí ☐ No

☐ Dirección: _____

Elija inscribirse firmando aquí _____ _____
Firma del Paciente o de la Persona Legalmente Autorizada (Debe firmar aquí para inscribirse en el programa de asistencia al paciente) | Fecha de la Firma

Genentech BioOncology®, su logotipo y el logotipo de Access Solutions son marcas comerciales registradas de Genentech, Inc

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STATEMENT OF MEDICAL NECESSITY (SMN)
for Genentech BioOncology Access Solutions

BIOONCOLOGY™ | Access Solutions®

Phone: (888) 249-4918 Fax: (888) 249-4919 Genentech-Access.com/BioOncology
Please note - ALL fields denoted with an asterisk (*) are required fields.

INFUSED PRODUCTS

SERVICES REQUESTED* (check only those that apply)

- ☐ Benefits Investigation/Prior Authorization
- ☐ GATCF† Patient Assistance
- ☐ GATCF Eligibility Screening
- ☐ Appeals Support
- ☐ Co-pay Assistance

PATIENT INFORMATION

Last name* _____
First name* _____
Birth date* _____ Gender* ☐ Male ☐ Female
Street _____
City _____ State* _____ ZIP _____
Home phone _____
Work/cell phone _____
Email _____
OK to contact patient? ☐ Yes ☐ No
Alternate contact last name _____
First name _____
Relationship to patient _____
Alternate contact phone _____
Is patient deceased? ☐ Yes ☐ No

INSURANCE INFORMATION

☐ No insurance

Is the patient pending Medicaid determination? ☐ Yes ☐ No

Please attach a copy of the patient's insurance card

Primary insurance name: _____
Phone _____
Subscriber name _____
Subscriber ID # _____
Policy/group # _____

Secondary insurance name: _____
Phone _____
Subscriber name _____
Subscriber ID # _____
Policy/group # _____

Tertiary insurance name: _____
Phone _____
Subscriber name _____
Subscriber ID # _____
Policy/group # _____

*Required field Genentech BioOncology Access Solutions cannot process your SMN unless these fields are completed
†Genentech® Access to Care Foundation ‡National Provider Identifier §Provider Transaction Access Number

PATIENT MEDICAL INFORMATION

Indicate patient's therapy (check all that apply):

☐ **Avastin® (bevacizumab)** ☐ **RITUXAN® (Rituximab)**
☐ **Herceptin® (trastuzumab)** ☐ **PERJETA® (pertuzumab)**
☐ **KADCYLA® (ado-trastuzumab emtansine)**
☐ **GAZYVA™ (obinutuzumab)**

Has treatment started? ☐ Yes ☐ No Date _____

Place of administration:

☐ Physician's office ☐ Hospital outpatient ☐ Hospital inpatient

Primary ICD-9-CM code* _____ Description _____
(ICD-9 code required to the highest level of specificity)
Secondary ICD-9-CM code _____ Description _____
(ICD-9 code required to the highest level of specificity)

Clinical TNM stage:

☐ 0 ☐ I ☐ IIA ☐ IIB ☐ IIIA ☐ IIIB ☐ IIIC ☐ IV

Line of therapy*:

☐ First ☐ Second ☐ Other

Previous treatment:

☐ None ☐ Hormone therapy ☐ Radiation ☐ Surgery
☐ Other _____
Chemotherapy (please specify) _____
Concurrent treatment prescribed with Genentech product*: _____

If applicable, HER2 positive? ☐ Yes ☐ No
Test results FISH (ratio)_____ IHC____ 1+ ____ 2+ ____ 3+ Other _____
Adjuvant: ☐ Yes ☐ No

▷ **For RITUXAN Patients Only**

Disease characteristics:

☐ Indolent ☐ Aggressive ☐ CD20-positive

PRESCRIBER INFORMATION

Facility/practice name _____
Prescriber's last name* _____
First name* _____
Specialty ☐ Oncologist ☐ Other (specify) _____
Prescriber license # _____
Street* _____
City* _____ State* _____ ZIP* _____
Clinical/medical contact _____
Phone _____ Fax _____
Reimbursement contact _____
Phone _____ Fax _____
GATCF contact _____
Phone _____ Fax _____

Billing information for: ☐ Group ☐ Individual

Tax ID # _____
NPI‡ # _____
PTAN§ _____
DEA # _____

Print patient's name here

Last name* _____ First name* _____ Birth date* _____

SHIPPING FOR GATCF

Shipping location ☐ Patient ☐ Practice ☐ Facility Shipping address same as address listed on page 1 of this form? ☐ Yes ☐ No

If no, please complete the remainder of this section.

Facility/practice or patient name _____ DEA # _____ License # _____

Street (street address required, no PO boxes) _____

City _____ State _____ ZIP _____

Contact name _____

Phone _____ Fax _____

INSTRUCTIONS FOR USE

- Use this form to enroll all insured and uninsured patients needing Genentech BioOncology Access Solutions assistance

SERVICES REQUESTED

- Check the appropriate services requested Genentech BioOncology Access Solutions and/or GATCF cannot perform services without your specific authorization
  - Check GATCF Patient Assistance if patient has no insurance Patient may receive assistance through GATCF
  - Check GATCF Eligibility Screening if you would like a pretreatment check against the GATCF medical and financial criteria for your *insured* patients

INSURANCE INFORMATION

- Please check the appropriate boxes to reflect the patient's insurance status

PATIENT MEDICAL INFORMATION

- The diagnosis, line of therapy and concurrent treatment prescribed with Genentech products sections must be completed

SHIPPING FOR GATCF

- Indicate where you would like the product to be shipped if the patient meets the required medical and income criteria for GATCF

PLEASE ATTACH THE FOLLOWING:

- A signed and dated Patient Authorization and Notice of Release of Information (PAN) form
- A front and back copy (enlarged and legible) of the patient's insurance card
- If your claim or prior authorization submission has been denied, include a completed GATCF Insurance Attestation form No further documentation is necessary
- Providing additional documents or information with this form will delay processing

UNAPPROVED USE WARNING: Please read the FDA-approved label for Genentech BioOncology products before prescribing If the indication for which you are prescribing a Genentech BioOncology product is not listed in the label, you are prescribing the medication for an "unapproved" use The fact that the use for which you are prescribing this medication is not listed in the FDA-approved label indicates that the FDA has not approved the efficacy, dosage amount or safety of this medication when used for such a use Nevertheless, the Genentech® Access to Care Foundation (GATCF) will consider providing the medication for your patient with this admonition, based upon your medical order, within program requirements

By signing below, I certify that (a) the above therapy is medically necessary, (b) I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc , Genentech BioOncology Access Solutions and contracted dispensing pharmacy or other contractors for the purpose of seeking reimbursement, assisting in initiating or continuing therapy and/or the evaluation of the patient's eligibility for GATCF related to Genentech BioOncology products, as a break in treatment would negatively impact the patient's therapeutic outcome, (c) I will not attempt to seek reimbursement for free or replacement product provided directly to the patient or for the dates of service for which free or replacement product was provided and (d) I appoint Genentech BioOncology Access Solutions solely to convey on my behalf to the pharmacy chosen by the above-named patient the prescription described herein

I agree to comply with the program guidelines as established by Genentech, Inc and understand that GATCF, at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of the information submitted I further understand that Genentech will provide vial replacement in a configuration that will create the least amount of wastage

If applying for GATCF, I certify that this patient has no medical insurance coverage for the pharmaceutical identified above and is not eligible for other public health insurance programs

Sign and date here

Prescriber's Signature* _____ Date* _____

(This form cannot be processed without an original or stamped signature)

*Required field

Reminder: Genentech BioOncology Access Solutions cannot work with the insurance plan on your patient's behalf without a physician's signature and date, as well as a completed PAN form

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PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION (PAN)

BIOONCOLOGY | Access Solutions

ORAL PRODUCTS

Phone: (888) 249-4918 **Fax:** (877) 313-2659 **Genentech-Access.com/BioOncology**

ACS/092914/0043 10/14

Genentech BioOncology Access Solutions is a free program for you from Genentech.

We work to help you pay for your Genentech product. We can help in many different ways. We assist people who have a health care plan as well as those who don't.

If you don't have a health care plan, or your plan won't pay for your Genentech product(s), we might be able to help. If you meet certain financial and medical standards, we can supply free medicine. This is done through the Genentech® Access to Care Foundation (GATCF).

For us to help, we need to look at, use and disclose your personally identifiable information (PII). Your health care provider and health care plan can disclose your PII to us only with your written authorization. By signing this authorization form, you are authorizing your health care provider and health care plan to release your PII to us, and authorizing us to disclose your PII as necessary to perform services for you. Once you sign this form and it is sent back to us, or submitted electronically by you or by your health care provider on your behalf, we can start to provide these services. You can choose not to agree to this authorization, however, please note that we cannot provide our services without it. This means you might need to pay for certain medications on your own.

PLEASE READ THROUGH THIS FORM CAREFULLY. IF YOU HAVE ANY QUESTIONS, TALK TO YOUR HEALTH CARE PROVIDER'S OFFICE OR CALL US AT THE PHONE NUMBER LISTED AT THE TOP OF THIS PAGE.

1 INFORMATION TO BE DISCLOSED OR USED

This signed form lets my health care providers and health care plans send my PII, and this form electronically, to Genentech Access Solutions and/or GATCF. This includes:

- All my health records relating to my treatment
- Information about my health care plan benefits
- The dollar balance left on the total of the lifetime payments covered by my health care plan policy (if this applies to my plan)
- Any information having a bearing on my health or my adherence to my treatment

All of the above is considered part of my PII. I know this could include information about:

- Sexually transmitted diseases
- Mental health conditions
- Genetic test results

2 WHO MAY SEE AND USE MY PII

My PII may be seen by Genentech Access Solutions and/or GATCF. These are programs sponsored by Genentech. Its address is 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. It may also be seen by anyone helping Genentech Access Solutions perform services, including Genentech employees and any of Genentech's partners, for the purpose of facilitating access to Genentech products. Genentech may share your PII with Sponsors, and/or their agents and affiliates, and your health care provider and health plan.

My PII may be used only in these ways:

- Helping with my health care plan coverage for Genentech products
- Applying to GATCF
- Determining eligibility for alternative forms of coverage and sources of funding
- Coordination of prescription fulfillment through a pharmacy
- Tracking my use of Genentech products
- For Genentech, or our partners' administrative purposes

3 NOTICES

This authorization and notice of release is in effect for 1 year from the date I signed it.

Once I sign this form, I know my PII might not be covered by any federal law that restricts the use and disclosure of my PII. There is no guarantee my PII might not be released to a third party. This third party might not need to follow the conditions of this authorization and notice of release.

I know I can refuse to sign this form. I may withdraw authorization at any time and for any reason. This won't affect the start or continuing of my treatment, the quality of my treatment, and will have no impact on my treatment by my health care provider. To withdraw it, I must send a written notice to Genentech. It can be sent by fax or by mail to the address on this page. This withdrawal goes into effect once it is received by Genentech. If I don't sign this form or if I withdraw my authorization, Genentech will not be able to help me with access to my Genentech product(s).

I understand that I, as the patient or signer, have a right to obtain a copy of this signed authorization and notice of release during the one year it is valid, and up to three years after it is signed.

4 DISTRIBUTION ACCEPTANCE

If I receive free product from GATCF, I will use Genentech products as my health care provider has prescribed them to me. I will not sell or distribute Genentech products. I understand it is unlawful to do this. I am responsible for ensuring any Genentech product is sent to a secure address when it is shipped to me. I know it is my duty to control any Genentech product while it stays in my possession.

This written notice must be signed, dated, and mailed, faxed, or electronically submitted to

Genentech Access Solutions
1 DNA Way, Mail Stop #858a
South San Francisco, CA 94080-4990

Fax: (877) 313-2659

5 SIGNATURE AND DATE (REQUIRED)

I have read this document or have had it explained to me. By signing this form, I know I am authorizing the release and disclosure of my PII as discussed in this authorization form. **Please fill in all information below. Be sure to sign and date this form. If you don't, it could hold up the process for helping you.**

You must sign and date here

_____ Signature of Patient or Legally Authorized Person

_____ Relationship to Patient

_____ Date Signed

You must print your name here

_____ Print Patient's Name

_____ Patient/Alternate Contact Address

If signing for the patient you must print your name here

_____ Legally Authorized Person/Alternate Contact Name

_____ Contact Phone

☐ OK to leave a detailed message*: I authorize Genentech Access Solutions/GATCF to leave a detailed message at the following number: _____

*I understand this message may include PII, including but not limited to, the name of the medication I have been prescribed, my doctor's name, and details regarding insurance coverage

If signing for the patient, print your name here

6 FINANCIAL INFORMATION (GATCF ONLY)

TOTAL HOUSEHOLD INCOME FOR THE PREVIOUS CALENDAR YEAR: $ _____

Read the following attestation: I understand that to qualify for free medicine, GATCF has criteria that must be met, including income. I certify the above statement of my total annual household income for the previous calendar year is true, and I do not have the financial resources or insurance coverage to pay for Genentech products. I know that GATCF could ask me for a copy of my IRS 1040 form or other proof of income for the purpose of an audit. I agree to provide my financial documentation in a timely manner, if so requested. In addition, I will notify GATCF immediately if my insurance situation changes. Please note that GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the financial attestation is false or inaccurate. By signing this attestation, I certify that the above statement of my annual household income amount is true and accurate, to the best of my knowledge.

Sign and date here (Required for GATCF Enrollment)

_____ Signature of Patient or Legally Authorized Person

_____ Date Signed

7 AN OPTIONAL AND FREE PATIENT SUPPORT PROGRAM

I want to enroll in an optional and free patient support program from Genentech. I understand my PII is needed for me to be a part of this program. I also know my PII will be shared with Genentech Access Solutions and the patient support program. I may choose to be contacted by mail, email or phone. I understand my PII won't be shared outside of Genentech, or by its agents. I agree to let Genentech or its agents contact me in the future about this program.

The Genentech privacy policy can be found at Genentech-Access.com. I understand I do not have to sign this part of the form. It plays no role in getting my medicine. It is not part of receiving help from Genentech Access Solutions. I also know I may cancel this enrollment in the patient support program at any time. To cancel, I can call (877) 436-3683.

Preferred way to contact me (Please check the box that applies and fill in your information. You can check more than one box.):
☐ Email: _____ ☐ Phone Number: _____ Okay to leave a message? ☐ Yes ☐ No
☐ Address: _____

Choose to enroll by signing here

_____ Signature of Patient/Legally Authorized Person (You must sign here to enroll in the patient support program.)

_____ Date Signed

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Genentech
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AUTORIZACIÓN DEL PACIENTE Y AVISO DE DIVULGACIÓN DE INFORMACIÓN (PAN)

BIOONCOLOGY | Access Solutions

PRODUCTOS ORALES

Teléfono: (888) 249-4918 **Fax:** (877) 313-2659 **Genentech-Access.com/BioOncology**

ACS/091814/0026(1) 10/14

Genentech BioOncology Access Solutions es un programa gratuito de Genentech para usted.

Trabajamos para ayudarlo a pagar su producto de Genentech. Podemos ayudarlo de muchas maneras diferentes. Ayudamos a las personas que cuentan con un plan de salud y a quienes no lo tienen.

Si no tiene plan de salud, o si su plan no pagará por su(s) producto(s) de Genentech, es posible que podamos ayudarlo. Si cumple con ciertos estándares financieros y médicos, podemos proporcionarle el medicamento en forma gratuita. Esto se hace a través de la Genentech® Access to Care Foundation (GATCF).

Para ayudarlo, necesitamos ver, usar y revelar su información personal identificable (personally identifiable information, PII). Su proveedor de atención médica y su plan de salud pueden revelarnos su PII únicamente con su autorización por escrito. Al firmar este formulario de autorización, usted autoriza a su proveedor de atención médica y a su plan de salud a entregarnos su PII, y nos autoriza a revelar su PII según sea necesario para proporcionarle servicios. Una vez que firme este formulario y este se nos envíe de regreso, o usted o su proveedor de atención médica en su nombre nos lo envíen electrónicamente, podemos empezar a proporcionarle estos servicios. Usted puede optar por no acceder a esta autorización, sin embargo, tenga en cuenta que no podemos proporcionarle nuestros servicios sin ella. Esto significa que podría ser necesario que pague ciertos medicamentos por su propia cuenta.

LEA CUIDADOSAMENTE ESTE FORMULARIO. SI TIENE PREGUNTAS, HABLE CON EL CONSULTORIO DE SU PROVEEDOR DE ATENCIÓN MÉDICA O LLÁMENOS AL NÚMERO TELEFÓNICO QUE APARECE EN LA PARTE SUPERIOR DE ESTA PÁGINA.

1 INFORMACIÓN QUE SE REVELARÁ O USARÁ

Este formulario firmado les permite a mis proveedores de atención médica y planes de salud enviar mi PII, y este formulario en forma electrónica, a Genentech Access Solutions y/o a la GATCF. Esto incluye:

- Todos mis registros médicos relacionados con mi tratamiento
- Información sobre los beneficios de mi plan de salud
- El saldo en dólares que queda del total de los pagos de por vida que cubre la póliza de mi plan de salud (si esto se aplica a mi plan)
- Toda información relacionada con mi salud o el cumplimiento de mi tratamiento

Todo lo mencionado arriba se considera parte de mi PII. Sé que esto podría incluir información sobre:

- Enfermedades de transmisión sexual
- Afecciones de salud mental
- Resultados de pruebas genéticas

2 QUIÉN PUEDE VER Y USAR MI PII

Mi PII puede ser vista por Genentech Access Solutions y/o la GATCF. Estos son programas que patrocina Genentech. Su dirección es 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. También puede ser vista por cualquier persona que ayude a Genentech Access Solutions en la prestación de servicios, lo que incluye a empleados de Genentech y a cualquier socio de Genentech, a los efectos de facilitar el acceso a los productos de Genentech. Genentech puede compartir su PII con los Patrocinadores, y/o sus agentes y afiliadas, y con su proveedor de atención médica y plan de salud.

Mi PII se puede usar solamente de las maneras siguientes:

- Ayudarme con la cobertura de mi plan de salud para productos de Genentech
- Presentar una solicitud a la GATCF
- Determinar la elegibilidad para formas de cobertura y fuentes de financiamiento alternativas
- Coordinación del surtido de recetas a través de una farmacia
- Rastrear mi uso de productos de Genentech
- Para fines administrativos de Genentech o de nuestros socios

3 AVISOS

Esta autorización y aviso de divulgación tiene vigencia durante 1 año a partir de la fecha en que la firmé.

Una vez que firme este formulario, sé que mi PII podría no estar cubierta por las leyes federales que restringen el uso y la divulgación de mi PII. No existe ninguna garantía de que mi PII no se revele a un tercero. Es posible que este tercero no necesite cumplir con las condiciones de esta autorización y aviso de divulgación.

Sé que puedo negarme a firmar este formulario. Puedo retirar la autorización en cualquier momento y por cualquier razón. Esto no afectará el inicio ni la continuación de mi tratamiento, tampoco afectará la calidad de mi tratamiento, ni tendrá efecto alguno en el tratamiento que me brinda mi proveedor de atención médica. Debo enviar un aviso por escrito a Genentech para retirarla. Puedo enviarlo por fax o por correo postal a la dirección que se muestra en esta página. Este retiro entra en vigencia una vez que Genentech lo recibe. Si no firmo este formulario o si retiro mi autorización, Genentech no podrá ayudarme con el acceso a mi(s) producto(s) de Genentech.

Comprendo que, como paciente o firmante, tengo derecho a obtener una copia de esta autorización y aviso de divulgación firmada durante el año en que tenga validez, y hasta tres años después de que se firme.

4 ACEPTACIÓN DE DISTRIBUCIÓN

Si recibo productos gratuitos de la GATCF, usaré los productos de Genentech como mi proveedor de atención médica me los recetó. No venderé o distribuiré los productos de Genentech. Entiendo que es ilegal hacerlo. Soy responsable de asegurarme de que cualquier producto de Genentech se envíe a una dirección segura cuando me hagan el envío. Sé que es mi deber controlar cualquier producto de Genentech mientras esté en mi poder.

Este aviso por escrito se debe firmar, fechar y enviar por correo postal, fax o en forma electrónica a:

Genentech Access Solutions
1 DNA Way, Mail Stop #858a
South San Francisco, CA 94080-4990

Fax: (877) 313-2659

5 FIRMA Y FECHA (OBLIGATORIAS)

He leído este documento o me lo han explicado. Al firmar este formulario, sé que estoy autorizando la divulgación y entrega de mi PII como se analiza en este formulario de autorización. **Complete toda la información a continuación. Asegúrese de firmar y fechar este formulario. Si no lo hace, se podría retrasar el proceso para brindarle ayuda.**

Debe firmar y colocar la fecha aquí

_____ _____ _____
Firma del Paciente o de la Persona Legalmente Autorizada | Relación con el Paciente | Fecha de la Firma

Debe poner aquí su nombre, en letra de imprenta

_____ _____
Nombre del Paciente, en Letra de Imprenta | Dirección del Paciente/Contacto Alternativo

Si firma por el paciente, debe poner aquí su nombre, en letra de imprenta

_____ _____
Nombre de la Persona Legalmente Autorizada/Nombre del Contacto Alternativo | Teléfono del Contacto

☐ Se puede dejar un mensaje detallado*: Autorizo a Genentech Access Solutions/la GATCF a dejar un mensaje detallado en el siguiente número: _____

*Comprendo que este mensaje puede incluir PII, lo cual comprende, pero no se limita a, el nombre del medicamento que se me recetó, el nombre de mi médico y detalles relativos a la cobertura de seguro

6 INFORMACIÓN FINANCIERA (GATCF ÚNICAMENTE)

INGRESOS FAMILIARES TOTALES CORRESPONDIENTES AL AÑO CALENDARIO PREVIO: $ _____

Lea el testimonio siguiente: Comprendo que para reunir los requisitos a fin de recibir medicamentos gratuitos, la GATCF tiene ciertos criterios que se deben cumplir, lo que incluye los ingresos. Certifico que mi declaración anterior de los ingresos familiares totales correspondientes al año calendario previo es verdadera, y que no cuento con recursos económicos ni cobertura de seguro para pagar los productos de Genentech. Sé que la GATCF podría solicitarme una copia de mi formulario 1040 del IRS u otra prueba de mis ingresos para propósitos de auditoría. Estoy de acuerdo con proporcionar en forma oportuna mis documentos financieros, si me los solicitan. Además, notificaré inmediatamente a la GATCF si cambia mi situación de seguro. Tenga en cuenta que la GATCF ejercerá todos los recursos legales apropiados, lo que incluye un juicio de indemnización por daños y perjuicios en litigio, en el caso de que la GATCF determine que esta certificación es falsa o que el testimonio financiero es falso o inexacto. Al firmar este testimonio, certifico que el monto de mis ingresos familiares anuales declarados arriba es verdadero y exacto, a mi leal saber y entender.

Firme y coloque la fecha aquí (Se requiere para la inscripción en la GATCF)

_____ _____
Firma del Paciente o de la Persona Legalmente Autorizada | Fecha de la Firma

7 UN PROGRAMA OPCIONAL Y GRATUITO DE ASISTENCIA AL PACIENTE

Deseo inscribirme en un programa opcional y gratuito de asistencia al paciente brindado por Genentech. Entiendo que se necesita mi PII para que pueda participar en este programa. También sé que se compartirá mi PII con Genentech Access Solutions y con el programa de asistencia al paciente. Puedo elegir que se me contacte por correo, correo electrónico o teléfono. Entiendo que mi PII no será compartida fuera de Genentech, ni por sus agentes. Acepto que Genentech o sus agentes se pongan en contacto conmigo en el futuro sobre este programa.

La política de privacidad de Genentech se puede encontrar en Genentech-Access.com. Entiendo que no tengo que firmar esta parte del formulario. No tiene ningún efecto a la hora de obtener mi medicamento. No forma parte de recibir asistencia de Genentech Access Solutions. También sé que puedo cancelar esta inscripción en el programa de asistencia al paciente en cualquier momento. Para cancelar, puedo llamar al (877) 436-3683.

Forma preferida de ponerse en contacto conmigo (Marque el casillero que corresponda y complete su información. Puede marcar más de un casillero.).

☐ Correo electrónico: _____ ☐ Número de teléfono: _____ ¿Se puede dejar un mensaje? ☐ Sí ☐ No

☐ Dirección: _____

Elija inscribirse firmando aquí

_____ _____
Firma del Paciente o de la Persona Legalmente Autorizada (Debe firmar aquí para inscribirse en el programa de asistencia al paciente) | Fecha de la Firma

Genentech BioOncology®, su logotipo y el logotipo de Access Solutions son marcas comerciales registradas de Genentech, Inc

Genentech
A Member of the Roche Group

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STATEMENT OF MEDICAL NECESSITY (SMN)
for Genentech BioOncology™ Access Solutions

BIOONCOLOGY™ Access Solutions®

Phone: (888) 249-4918 Fax: (877) 313-2659 Genentech-Access.com/BioOncology
Please note - ALL fields denoted with an asterisk (*) are required fields.

ORAL PRODUCTS

SERVICES REQUESTED*
(check only those that apply)

- ☐ Benefits Investigation/Prior Authorization
- ☐ GATCF† Patient Assistance
- ☐ Appeals Support
- ☐ Co-pay Assistance

PATIENT INFORMATION

Last name* _____ First name* _____
Birth date* _____ Gender* ☐ Male ☐ Female
Street _____
City _____ State* _____ ZIP _____
Home phone _____
Work/cell phone _____ Email _____
OK to contact patient? ☐ Yes ☐ No
Alternate contact last name _____
First name _____
Relationship to patient _____
Alternate contact phone _____

INSURANCE INFORMATION

☐ No insurance
Is the patient pending Medicaid determination? ☐ Yes ☐ No
Please attach a copy of the patient's insurance card

Primary insurance (PI) name: _____
PI phone _____
PI subscriber name _____
PI subscriber ID # _____
Policy/group # _____

Secondary insurance (SI) name: _____
SI phone _____
SI subscriber name _____
SI subscriber ID # _____
Policy/group # _____

PHARMACY PREFERENCE (Optional)

☐ Specialty ☐ Retail ☐ Onsite dispensing pharmacy
Pharmacy name _____
Phone _____
Contact person _____

For Erivedge, Tarceva and ZELBORAF, unless the patient requests otherwise, the prescription will be directed to the authorized specialty pharmacy providing the lowest cost-sharing for the patient. If more than one specialty pharmacy is found, a specialty pharmacy will be selected for the patient based on uniformly applied selection criteria.

CLINICAL TRIAL PATIENT

Clinical Trial Patient? ☐ Yes ☐ No
If Yes, study site _____

*Required field. Genentech BioOncology Access Solutions cannot process your SMN unless these fields are completed.
†Genentech® Access to Care Foundation ‡National Provider Identifier §Provider Transaction Access Number

PATIENT MEDICAL INFORMATION

Indicate patient's therapy (check all that apply):
☐ **Erivedge® (vismodegib)** ☐ **Tarceva® (erlotinib)**
☐ **XELODA® (capecitabine)** ☐ **ZELBORAF® (vemurafenib)**

Has treatment started? ☐ Yes ☐ No Date _____
Primary ICD-9-CM code* _____
(required to the highest level of specificity)
Secondary ICD-9-CM code _____
(required to the highest level of specificity)

Clinical TNM stage:
☐ 0 ☐ I ☐ IIA ☐ IIB ☐ IIIA ☐ IIIB ☐ IIIC ☐ IV

Line of therapy*:
☐ First ☐ Second ☐ Other

Previous treatment:
☐ None ☐ Hormone therapy ☐ Radiation
☐ Surgery ☐ Other _____
Chemotherapy (please specify) _____

PRESCRIBER INFORMATION

Facility/practice name _____
Prescriber's last name* _____
First name* _____
Specialty ☐ Oncologist ☐ Other (specify) _____
Prescriber license # _____
Street* _____
City* _____ State* _____ ZIP* _____
Clinical/medical contact _____
Phone _____ Fax _____
Reimbursement contact _____
Phone _____ Fax _____
GATCF contact _____
Phone _____ Fax _____

Billing information for: ☐ Group ☐ Individual
Tax ID # _____
NPI‡ # _____
PTAN§ _____
DEA # _____

SHIPPING FOR GATCF

Shipping location ☐ Patient ☐ Facility ☐ Practice
Shipping address same as address listed above? ☐ Yes ☐ No
If no, please complete the remainder of this section.
Facility/practice or patient name _____
DEA # _____ License # _____
Street (street address required, no PO boxes) _____
_____
City _____ State _____ ZIP _____
Contact name _____
Phone _____ Fax _____

Print patient's name here

Patient last name* _____ First name* _____ Birth date* _____

For Erivedge® (vismodegib) patients only:

Metastatic basal cell carcinoma?* ☐ Yes ☐ No

Locally advanced basal cell carcinoma recurred following surgery or not candidate for surgery?* ☐ Yes ☐ No

Locally advanced basal cell carcinoma not candidate for radiation?* ☐ Yes ☐ No

WARNING: Erivedge can result in embryo-fetal death or severe birth defects. Verify pregnancy status prior to initiation of Erivedge. Advise male and female patients of these risks. Advise females of the need for contraception and advise males of the potential risk of Erivedge exposure through semen.

Erivedge prescription

☐ **150 mg daily** ☐ Other _____

Dispense _____-month supply Refill _____times

Erivedge Sure Start™ free starter supply

☐ **150 mg daily**

Dispense 14-day supply Refill _____times

For ZELBORAF® (vemurafenib) patients only:

Clinical TNM stage*:

☐ Metastatic melanoma/unresectable ☐ Other

Previous treatment(s) specific to ZELBORAF:

☐ Interleukin-2 ☐ Ipilimumab ☐ Interferon-alpha

Confirmed positive for the BRAF^{V600E} mutation?*

☐ Yes ☐ No

Limitation of Use: ZELBORAF is not recommended for use in patients with wild-type BRAF melanoma.

ZELBORAF prescription

☐ **960 mg twice a day** ☐ Other _____

Dispense _____-day supply Refill _____times

ZELBORAF Sure Start free starter supply

☐ **960 mg twice a day**

Dispense 15-day supply Refill _____times

For XELODA® (capecitabine) patients only:

XELODA 500 mg:

Take ____tablets ____ times per day for ____ days, then off for ____days

SIG (Other) _____

# of tablets per cycle _____ 500 mg

XELODA 150 mg:

Take ____ tablets ____ times per day for ____ days, then off for ____ days

SIG (Other) _____

# of tablets per cycle _____ 150 mg

# of cycles per fill: ☐ 2 ☐ 3 Other _____

# of refills: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Other _____

For Tarceva® (erlotinib) patients only:

First-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test? ☐ Yes ☐ No

Maintenance treatment of patients with locally advanced or metastatic NSCLC whose disease has not progressed after 4 cycles of platinum-based first-line chemotherapy? ☐ Yes ☐ No

Treatment of patients with locally advanced or metastatic NSCLC after failure of at least 1 prior chemotherapy regimen? ☐ Yes ☐ No

First-line treatment of patients with locally advanced, unresectable or metastatic pancreatic cancer, in combination with gemcitabine? ☐ Yes ☐ No

Limitations of Use: Tarceva is not recommended for use in combination with platinum-based chemotherapy. Safety and efficacy of Tarceva have not been evaluated as first-line treatment in patients with metastatic NSCLC whose tumors have EGFR mutations other than exon 19 deletions or exon 21 (L858R) substitution.

Tarceva prescription

☐ **150 mg daily** ☐ **100 mg daily** ☐ Other _____mg daily

Dispense _____-day supply Refill _____times

Tarceva Sure Start free starter supply

☐ **150 mg daily** ☐ **100 mg daily**

Dispense 15-day supply Refill _____times

UNAPPROVED USE WARNING: Please read the FDA-approved label for Genentech BioOncology™ products before prescribing If the indication for which you are prescribing Genentech BioOncology products is not listed in the label, you are prescribing the medication for an "unapproved" use The fact that the use for which you are prescribing this medication is not listed in the FDA-approved label indicates that the FDA has not approved the efficacy, dosage amount or safety of this medication when used for such a use Nevertheless, the Genentech® Access to Care Foundation (GATCF) will consider providing the medication for your patient with this admonition, based upon your medical order, within program requirements

By signing below, I certify that (a) the above therapy is medically necessary, (b) I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc , Genentech BioOncology Access Solutions and contracted dispensing pharmacy or other contractors for the purpose of seeking reimbursement, assisting in initiating or continuing therapy and/or the evaluation of the patient's eligibility for GATCF related to Genentech BioOncology products, as a break in treatment would negatively impact the patient's therapeutic outcome, (c) I will not attempt to seek reimbursement for free product provided directly to the patient and (d) I appoint Genentech BioOncology Access Solutions solely to convey on my behalf to the pharmacy chosen by the above-named patient the prescription described herein

I agree to comply with the program guidelines as established by Genentech, Inc and understand that GATCF, at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of the information submitted

If applying for GATCF, I certify that this patient has no medical insurance coverage for the pharmaceutical identified above and is not eligible for other public health insurance programs

Sign and date here

Prescriber's Signature* _____ Date* _____

(This form cannot be processed without an original signature)

*Required field

INSTRUCTIONS FOR USE

- Use this form to enroll all insured and uninsured patients needing Genentech BioOncology™ Access Solutions assistance

SERVICES REQUESTED

- Check the appropriate services requested. Genentech BioOncology Access Solutions and/or GATCF cannot perform services without your specific authorization·
  - Check GATCF Patient Assistance if patient has no insurance Patient may receive assistance through GATCF
- Additional medical documents/information may be needed based on the services requested

INSURANCE INFORMATION

- Please check the appropriate boxes to reflect the patient's insurance status

Clinical Trial Patient

- Please complete if your patient is currently involved in a clinical trial

Sure Start™ Free Starter Supply

- To request a starter supply of Erivedge® (vismodegib), Tarceva® (erlotinib) or ZELBORAF® (vemurafenib), please complete the Sure Start prescription
- Payers may not be billed for a starter supply of Erivedge, Tarceva or ZELBORAF
- For eligibility criteria, please visit Genentech-Access com/Erivedge, Genentech-Access com/Tarceva or Genentech-Access.com/ZELBORAF and/or speak to your Erivedge Access Solutions, Tarceva Access Solutions or ZELBORAF Access Solutions Specialist

SHIPPING FOR GATCF

- Indicate where you would like the product to be shipped if the patient meets the required medical and income criteria for GATCF

PLEASE ATTACH THE FOLLOWING:

- A signed and dated Patient Authorization and Notice of Release of Information (PAN) form
- A front and back copy (enlarged and legible) of the patient's insurance card. For Tarceva patients, please provide a front and back copy of the patient's drug card
- If your claim or prior authorization submission has been denied, include a copy of the denial letter

Reminder: Genentech BioOncology Access Solutions cannot work with the insurance plan on your patient's behalf without a physician's signature and date, as well as a completed PAN form.

Tarceva® is a registered trademark of OSI Pharmaceuticals, LLC, an affiliate of Astellas Pharma US, Inc
Genentech BioOncology™ is a trademark and Erivedge®, XELODA®, ZELBORAF®
and the Access Solutions logo are registered trademarks of Genentech, Inc

BIOONCOLOGY™ Access Solutions®

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Genentech® Access to Care Foundation (GATCF)
Insurance Attestation – Patient-Administered Drugs

Phone (888) 249-4918 - Fax (877) 313-2659

This form is required for each of your patient's insurances and will serve as proof that the patient's insurance company will not cover the prescribed Erivedge® (vismodegib) therapy. Complete this form when the outcome for any situations listed below has been met.

Check ALL box(es) that apply to your patient and fax to GATCF at the number listed above.

- ❑ My office received an initial claim denial or Prior Authorization (PA) denial.
  - Date of initial claim denial or PA denial: _____/_____/_____
  - Reason for denial: _____
- ❑ My office has submitted for a first-level appeal.
  - Date appeal letter submitted: _____/_____/_____
- ❑ My office received a first-level appeal denial.
  - Date of appeal denial letter: _____/_____/_____
  - Reason for denial: _____
- ❑ My office received a peer-to-peer denial.
  - Date of review: _____/_____/_____
  - Reason for denial: _____
- ❑ My patient has met the daily/yearly CAP for insurance coverage.
  - Date CAP was met: _____/_____/_____
  - Date CAP reset: _____/_____/_____

PLEASE NOTE: If the patient's insurance denied coverage due to an administrative error, untimely filing or not following the insurance policy requirements, your patient does not meet GATCF insurance criteria. GATCF requires one level of appeal for patients to be considered rendered uninsured.

Please complete, sign and date the following statement. (REQUIRED)

Authorized HCP Signature (Required)*: _____ Date: _____

Print Physician First and Last Name: _____

Patient Insurance Company Name: _____

Print Patient's First and Last Name: _____

Patient's Date of Birth: _____

CERTIFICATION: By signing above, I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements.

I know GATCF could ask me for a copy of the patient's insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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STATEMENT OF MEDICAL NECESSITY (SMN)
for Erivedge Access Solutions

Please write legibly and complete all required fields (*) to prevent delays

Please attach a signed and dated Patient Authorization and Notice of Release of Information (PAN) form

Phone: (888) 249-4918 Fax: (877) 313-2659 Genentech-Access.com/Erivedge

Erivedge® (vismodegib) capsule

Access Solutions®

SERVICES REQUESTED* (check only those that apply)

- ☐ Benefits Investigation/Prior Authorization
- ☐ GATCF† Patient Assistance
- ☐ Appeals Support
- ☐ Co-pay Assistance

PATIENT INFORMATION

Last name* _____ First name*: _____

Birth date*: _____ Gender*. ☐ Male ☐ Female

Street. _____

City: _____ State*. ____ ZIP. _____

Home phone. (____)_____

Work/Cell phone. (____)_____

Alternate contact last name. _____

First name. _____

Alternate contact phone. (____)_____

Relationship to patient. _____

OK to contact patient? ☐ Yes ☐ No

INSURANCE INFORMATION

☐ No insurance

Is the patient pending Medicaid determination? ☐ Yes ☐ No

Please attach copies of all the patient's insurance cards.

Primary insurance (PI) name: _____

_____

PI phone. _____

PI subscriber name. _____

PI subscriber ID #. _____

☐ No secondary insurance

Secondary insurance (SI) name: _____

_____

SI phone. _____

SI subscriber name. _____

SI subscriber ID #. _____

PHARMACY PREFERENCE (OPTIONAL)

☐ Specialty pharmacy

☐ Onsite dispensing pharmacy

Pharmacy name. _____

Phone. (____)_____

Contact person. _____

Unless the patient requests otherwise, the prescription will be directed to the authorized specialty pharmacy providing the lowest cost-sharing for the patient. If more than one specialty pharmacy is found, a specialty pharmacy will be selected for the patient based on uniformly applied selection criteria.

CLINICAL TRIAL PATIENT

Clinical trial patient? ☐ Yes ☐ No

If yes, study site. _____

PRESCRIBER INFORMATION

Facility/Practice name. _____

Prescriber last name*: _____

Prescriber first name*. _____

Prescriber license #: _____

Specialty. ☐ Dermatologist ☐ Mohs

☐ Other (specify): _____

Street*: _____

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

Phone. (____) _____

Fax. (____)_____

Reimbursement contact._____

Phone. (____) _____

Fax: (____)_____

Billing information for: ☐ Group ☐ Individual

Tax ID #: _____

NPI‡ #. _____

DEA #. _____

SHIPPING FOR GATCF

Indicate where you would like the product to be shipped if the patient meets the required medical and income criteria for GATCF.

Shipping location. ☐ Patient ☐ Facility ☐ Practice

Shipping address same as address listed in above section?

☐ Yes ☐ No

If no, please complete the remainder of this section.

Facility/Practice or patient name: _____

License #. _____

Street (street address required, no PO boxes): _____

_____

City: _____ State. _____ ZIP. _____

Contact name _____

Phone. _____ Fax: _____

Erivedge® (vismodegib) capsule is a hedgehog pathway inhibitor indicated for the treatment of adults with metastatic basal cell carcinoma, or with locally advanced basal cell carcinoma that has recurred following surgery or who are not candidates for surgery, and who are not candidates for radiation.

*Required field †Genentech® Access to Care Foundation ‡National Provider Identifier

Print patient's name here

Patient last name*: _____ **First name*:** _____ **Birth date*:** _____

PATIENT MEDICAL INFORMATION

Please complete the following appropriately*

Metastatic basal cell carcinoma
☐ Yes ☐ No

OR

Locally advanced basal cell carcinoma recurred following surgery or not candidate for surgery
☐ Yes ☐ No

AND

Locally advanced basal cell carcinoma not candidate for radiation
☐ Yes ☐ No

Diagnosis: ICD-9-CM code*

☐ 173 01 Basal cell carcinoma of skin of lip
☐ 173 11 Basal cell carcinoma of eyelid, including canthus
☐ 173 21 Basal cell carcinoma of skin of ear and external auditory canal
☐ 173.31 Basal cell carcinoma of skin of other and unspecified parts of face
☐ 173 41 Basal cell carcinoma of scalp and skin of neck
☐ 173.51 Basal cell carcinoma of skin of trunk, except scrotum
☐ 173.61 Basal cell carcinoma of skin of upper limb, including shoulder
☐ 173 71 Basal cell carcinoma of skin of lower limb, including hip
☐ 173.81 Basal cell carcinoma of other specified sites of skin
☐ 173 91 Basal cell carcinoma of skin, site unspecified
☐ ___ __ Other code

Previous treatment(s):

☐ None ☐ Surgery ☐ Radiation ☐ Chemotherapy ☐ Other _____

PRESCRIPTION

Erivedge® (vismodegib) capsule 150 mg

☐ **150 mg daily** ☐ Other. _____

Dispense: _____-month supply Refill _____ times

Erivedge Sure Start™ free starter supply

☐ **150 mg daily**

Dispense: 14-day supply Refill _____ times

WARNING: EMBRYO-FETAL DEATH AND SEVERE BIRTH DEFECTS

See full prescribing information for complete boxed warning.

Erivedge can result in embryo-fetal death or severe birth defects. Verify pregnancy status prior to initiation of Erivedge. Advise male and female patients of these risks. Advise females of the need for contraception and advise males of the potential risk of Erivedge exposure through semen

UNAPPROVED USE WARNING: Please read the FDA-approved label for Erivedge before prescribing. If the indication for which you are prescribing Erivedge is not listed in the label, you are prescribing the medication for an "unapproved" use. The fact that the use for which you are prescribing this medication is not listed in the FDA-approved label indicates that the FDA has not approved the efficacy, dosage amount or safety of this medication when used for such a use Nevertheless, the Genentech® Access to Care Foundation (GATCF) will consider providing the medication for your patient with this admonition, based upon your medical order, within program requirements

By signing below, I certify that (a) the above therapy is medically necessary, (b) I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc., Erivedge Access Solutions and contracted dispensing pharmacy or other contractors for the purpose of seeking reimbursement, assisting in initiating or continuing therapy and/or the evaluation of the patient's eligibility for GATCF related to Erivedge, as a break in treatment would negatively impact the patient's therapeutic outcome, (c) I will not attempt to seek reimbursement for free or replacement product provided directly to the patient or for the dates of service for which free or replacement product was provided and (d) I appoint Erivedge Access Solutions solely to convey on my behalf to the pharmacy chosen by the above-named patient the prescription described herein I further certify that I will not attempt to seek reimbursement for free or replacement product provided directly to the patient or for the dates of service for which free or replacement product was provided

I agree to comply with the program guidelines as established by Genentech, Inc and understand that GATCF, at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of the information submitted. I further understand that Genentech will provide vial replacement in a configuration that will create the least amount of wastage

If applying for GATCF, I certify that this patient has no medical insurance coverage for the pharmaceutical identified above and is not eligible for other public health insurance programs

Sign and date here

Prescriber's Signature* _____ Date* _____
(Original signature required)

*Required field

INSTRUCTIONS TO HEALTH CARE PROFESSIONALS FOR COMPLETING THE STATEMENT OF MEDICAL NECESSITY (SMN)

Use this form to enroll all insured and uninsured patients needing Erivedge Access Solutions assistance

SERVICES REQUESTED

- Check the appropriate services requested Erivedge Access Solutions and/or GATCF cannot perform services without your specific authorization
  - Check GATCF Patient Assistance if patient has no insurance Patient may receive assistance through GATCF
- Additional medical documents/information may be needed based on the services requested

SURE START™ PROGRAM

- To request a starter supply of Erivedge® (vismodegib) capsule, please complete the Sure Start prescription
- Payers may not be billed for a starter supply of Erivedge
- For eligibility criteria, please visit Genentech-Access.com/Erivedge and/or speak to your Erivedge Access Solutions Specialist

PLEASE ATTACH THE FOLLOWING

- A signed and dated Patient Authorization and Notice of Release of Information (PAN) form
- A front and back copy (enlarged and legible) of the patient's insurance card and a front and back copy of the patient's drug card
- If your claim or prior authorization submission has been denied, include a copy of the denial letter

REMINDER: Erivedge Access Solutions cannot work with the insurance plan on your patient's behalf without a physician's signature and date, as well as a completed PAN form.

Genentech-Access.com/Erivedge **Phone: (888) 249-4918** **Fax: (877) 313-2659**

Erivedge® and the Access Solutions logo are registered trademarks of Genentech, Inc

Erivedge® (vismodegib) capsule

Access Solutions®

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Genentech® Access to Care Foundation (GATCF)
Confirmation of Infusion or Injection

Phone (800) 530-3083 - Fax (877) 428-2326

This completed document is required to participate in the Genentech Access to Care Foundation (GATCF) free GAZYVA™ (obinutuzumab) program. This form is available online via My Patient Solutions™ for applicable brands*. Link to My Patient Solutions directly from Genentech-Access.com/GAZYVA to enroll and manage your patients online.

Instructions: *All fields required.* Complete this form after each infusion/injection and fax completed form to GATCF at the number listed above or submit through My Patient Solutions.

Date of Service:	Amount Infused/Injected:	Date of Service:	Amount Infused/Injected:
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg

Please complete, sign and date the following statement. (REQUIRED)

Print Patient Name (Required): _____

Patient's Date of Birth (Required): _____

Authorized HCP Signature (Required)†: _____

Date of Signature (Required): _____

Next Scheduled Infusion (if applicable): _____

CERTIFICATION: By signing above, I certify that all information on this form is correct, and this patient has been infused/injected with product listed above. I know that GATCF could ask me for a copy of the patient's infusion/injection records for the purpose of an audit. I agree to provide a copy of the patient's infusion/injection records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the Confirmation of Infusion or Injection is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*Only BioOncology products, Rheumatology products and XOLAIR are supported by My Patient Solutions.
†The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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Genentech® Access to Care Foundation (GATCF)
Insurance Attestation – HCP Administered Drugs

Phone (800) 530-3083 - Fax (877) 428-2326

This form is required for each of your patient's insurances and will serve as proof that the patient's insurance company will not cover the prescribed GAZYVA™ (obinutuzumab) therapy. This form should be completed once you have the outcome of the first level of appeal.

Check ALL box(es) that apply to your patient and fax to GATCF at the number listed above.

- ☐ My office received a first-level appeal denial and the initial claim or Prior Authorization (PA) denial is upheld.
  - Date of initial claim or PA denial: ____/____/____
  - Reason for initial claim or PA denial:_____
  - Date of first-level appeal denial: ____/____/____
  - Reason for first-level appeal denial:_____
- ☐ My office received a recoupment for date of service:____/____/____
  - Date of recoupment letter:____/____/____
  - Reason for recoupment:_____
- ☐ My office received a peer-to-peer denial.
  - Date of review:____/____/____
  - Reason denial:_____
- ☐ My patient has met the daily/yearly CAP for insurance coverage.
  - Date CAP was met:____/____/____
  - Date CAP reset:____/____/____

PLEASE NOTE: *If the patient's insurance denied coverage due to an administrative error, untimely filing or not following the insurance policy requirements, your patient does not meet GATCF insurance criteria. GATCF requires one level of appeal for patients to be considered rendered uninsured.*

Please complete, sign and date the following statement. (REQUIRED)

Authorized HCP Signature (Required): _____Date:_____

Print Physician First and Last Name: _____

Patient Insurance Company Name: _____

Print Patient's First and Last Name: _____

Patient's Date of Birth: _____

CERTIFICATION: By signing above, I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements.

I know GATCF could ask me for a copy of the patient's insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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Genentech® Access to Care Foundation (GATCF)
Confirmation of Infusion or Injection

Phone (800) 530-3083 - Fax (877) 428-2326

This completed document is required to participate in the Genentech Access to Care Foundation (GATCF) free Herceptin® (trastuzumab) program. This form is available online via My Patient Solutions™ for applicable brands*. Link to My Patient Solutions directly from Genentech-Access.com/Herceptin to enroll and manage your patients online.

Instructions: *All fields required.* Complete this form after each infusion/injection and fax completed form to GATCF at the number listed above or submit through My Patient Solutions.

Date of Service:	Amount Infused/Injected:	Date of Service:	Amount Infused/Injected:
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg

Please complete, sign and date the following statement. (REQUIRED)

Print Patient Name (Required): _____

Patient's Date of Birth (Required): _____

Authorized HCP Signature (Required)†: _____

Date of Signature (Required): _____

Next Scheduled Infusion (if applicable): _____

CERTIFICATION: By signing above, I certify that all information on this form is correct, and this patient has been infused/injected with product listed above. I know that GATCF could ask me for a copy of the patient's infusion/injection records for the purpose of an audit. I agree to provide a copy of the patient's infusion/injection records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the Confirmation of Infusion or Injection is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*Only BioOncology products, Rheumatology products and XOLAIR are supported by My Patient Solutions

†The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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Genentech® Access to Care Foundation (GATCF)
Insurance Attestation – HCP Administered Drugs

Phone (800) 530-3083 - Fax (877) 428-2326

This form is required for each of your patient's insurances and will serve as proof that the patient's insurance company will not cover the prescribed Herceptin® (trastuzumab) therapy. This form should be completed once you have the outcome of the first level of appeal.

Check ALL box(es) that apply to your patient and fax to GATCF at the number listed above.

- ☐ My office received a first-level appeal denial and the initial claim or Prior Authorization (PA) denial is upheld.
  - Date of initial claim or PA denial: ____/____/____
  - Reason for initial claim or PA denial:_____
  - Date of first-level appeal denial: ____/____/____
  - Reason for first-level appeal denial:_____
- ☐ My office received a recoupment for date of service:____/____/____
  - Date of recoupment letter:____/____/____
  - Reason for recoupment:_____
- ☐ My office received a peer-to-peer denial.
  - Date of review:____/____/____
  - Reason denial:_____
- ☐ My patient has met the daily/yearly CAP for insurance coverage.
  - Date CAP was met:____/____/____
  - Date CAP reset:____/____/____

PLEASE NOTE: *If the patient's insurance denied coverage due to an administrative error, untimely filing or not following the insurance policy requirements, your patient does not meet GATCF insurance criteria. GATCF requires one level of appeal for patients to be considered rendered uninsured.*

Please complete, sign and date the following statement. (REQUIRED)

Authorized HCP Signature (Required): _____ Date:_____

Print Physician First and Last Name: _____

Patient Insurance Company Name: _____

Print Patient's First and Last Name: _____

Patient's Date of Birth: _____

CERTIFICATION: By signing above, I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements.

I know GATCF could ask me for a copy of the patient's insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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Genentech® Access to Care Foundation (GATCF)
Confirmation of Infusion or Injection

Phone (800) 530-3083 - Fax (877) 428-2326

This completed document is required to participate in the Genentech Access to Care Foundation (GATCF) free KADCYLA® (ado-trastuzumab emtansine) program. This form is available online via My Patient Solutions™ for applicable brands*. Link to My Patient Solutions directly from Genentech-Access.com/KADCYLA to enroll and manage your patients online.

Instructions: *All fields required.* Complete this form after each infusion/injection and fax completed form to GATCF at the number listed above or submit through My Patient Solutions.

Date of Service:	Amount Infused/Injected:	Date of Service:	Amount Infused/Injected:
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg

Please complete, sign and date the following statement. (REQUIRED)

Print Patient Name (Required): _____

Patient's Date of Birth (Required): _____

Authorized HCP Signature (Required)†: _____

Date of Signature (Required): _____

Next Scheduled Infusion (if applicable): _____

CERTIFICATION: By signing above, I certify that all information on this form is correct, and this patient has been infused/injected with product listed above. I know that GATCF could ask me for a copy of the patient's infusion/injection records for the purpose of an audit. I agree to provide a copy of the patient's infusion/injection records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the Confirmation of Infusion or Injection is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*Only BioOncology products, Rheumatology products and XOLAIR are supported by My Patient Solutions

†The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP)

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Genentech® Access to Care Foundation (GATCF)
Insurance Attestation – HCP Administered Drugs

Phone (800) 530-3083 - Fax (877) 428-2326

This form is required for each of your patient's insurances and will serve as proof that the patient's insurance company will not cover the prescribed KADCYLA® (ado-trastuzumab emtansine) therapy. This form should be completed once you have the outcome of the first level of appeal.

Check ALL box(es) that apply to your patient and fax to GATCF at the number listed above.

❑ My office received a first-level appeal denial and the initial claim or Prior Authorization (PA) denial is upheld.

Date of initial claim or PA denial: ____/____/____

Reason for initial claim or PA denial:_____

Date of first-level appeal denial: ____/____/____

Reason for first-level appeal denial:_____

❑ My office received a recoupment for date of service:____/____/____

Date of recoupment letter:____/____/____

Reason for recoupment:_____

❑ My office received a peer-to-peer denial.

Date of review:____/____/____

Reason denial:_____

❑ My patient has met the daily/yearly CAP for insurance coverage.

Date CAP was met:____/____/____

Date CAP reset:____/____/____

PLEASE NOTE: If the patient's insurance denied coverage due to an administrative error, untimely filing or not following the insurance policy requirements, your patient does not meet GATCF insurance criteria. GATCF requires one level of appeal for patients to be considered rendered uninsured.

Please complete, sign and date the following statement. (REQUIRED)

Authorized HCP Signature (Required): _____Date:_____

Print Physician First and Last Name: _____

Patient Insurance Company Name: _____

Print Patient's First and Last Name: _____

Patient's Date of Birth: _____

CERTIFICATION: By signing above, I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements.

I know GATCF could ask me for a copy of the patient's insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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Genentech® Access to Care Foundation (GATCF)
Confirmation of Injection

Phone (800) 232-0592 - Fax (888) 727-7773

This completed document is required to participate in the Genentech Access to Care Foundation (GATCF) free LUCENTIS® (ranibizumab injection) program. This form is available online via My Patient Solutions™. Link to My Patient Solutions directly from Genentech-Access.com/LUCENTIS to enroll and manage your patients online.

Instructions: *All fields required.* Complete this form after each injection and fax completed form to GATCF at the number listed above or submit through My Patient Solutions.

Date of Service	Eye(s) Treated	Vial Size Used
/ /	☐ OD ☐ OS ☐ OU	☐ 0.3mg ☐ 0.5mg
/ /	☐ OD ☐ OS ☐ OU	☐ 0.3mg ☐ 0.5mg
/ /	☐ OD ☐ OS ☐ OU	☐ 0.3mg ☐ 0.5mg
/ /	☐ OD ☐ OS ☐ OU	☐ 0.3mg ☐ 0.5mg
/ /	☐ OD ☐ OS ☐ OU	☐ 0.3mg ☐ 0.5mg
/ /	☐ OD ☐ OS ☐ OU	☐ 0.3mg ☐ 0.5mg

Please complete, sign and date the following statement. (REQUIRED)

Print Patient Name (Required): _____

Patient's Date of Birth (Required): _____

Authorized HCP Signature (Required)*: _____

Date of Signature (Required): _____

Next Scheduled Injection (if applicable): _____

CERTIFICATION: By signing above, I certify that all information on this form is correct, and this patient has been injected with product listed above. I know that GATCF could ask me for a copy of the patient's injection records for the purpose of an audit and I agree to provide a copy of the patient's injection records in a timely manner upon such request. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the Confirmation of Injection is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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Genentech® Access to Care Foundation (GATCF)
Insurance Attestation – HCP Administered Drugs

Phone (800) 232-0592 - Fax (888) 727-7773

This form is required for each of your patient's insurances and will serve as proof that the patient's insurance company will not cover the prescribed LUCENTIS® (ranibizumab injection) therapy. This form should be completed once you have the outcome of the first level of appeal.

Check ALL box(es) that apply to your patient and fax to GATCF at the number listed above.

- ☐ My office received a first-level appeal denial and the initial claim or Prior Authorization (PA) denial is upheld.
  - Date of initial claim or PA denial: ____/____/____
  - Reason for initial claim or PA denial:_____
  - Date of first-level appeal denial: ____/____/____
  - Reason for first-level appeal denial:_____
- ☐ My office received a recoupment for date of service:____/____/____
  - Date of recoupment letter:____/____/____
  - Reason for recoupment:_____
- ☐ My office received a peer-to-peer denial.
  - Date of review:____/____/____
  - Reason denial:_____
- ☐ My patient has met the daily/yearly CAP for insurance coverage.
  - Date CAP was met:____/____/____
  - Date CAP reset:____/____/____

PLEASE NOTE: *If the patient's insurance denied coverage due to an administrative error, untimely filing or not following the insurance policy requirements, your patient does not meet GATCF insurance criteria. GATCF requires one level of appeal for patients to be considered rendered uninsured.*

Please complete, sign and date the following statement. (REQUIRED)

Authorized HCP Signature (Required): _____ Date:_____

Print Physician First and Last Name: _____

Patient Insurance Company Name: _____

Print Patient's First and Last Name: _____

Patient's Date of Birth: _____

CERTIFICATION: By signing above, I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements.

I know GATCF could ask me for a copy of the patient's insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION (PAN)

LUCENTIS® RANIBIZUMAB INJECTION | Access Solutions®

Phone: (866) 724-9394 **Fax:** (866) 724-9412 **Genentech-Access.com/LUCENTIS**

ACS/092914/0046 10/14

LUCENTIS Access Solutions is a free program for you from Genentech.

We work to help you pay for your Genentech product. We can help in many different ways. We assist people who have a health care plan as well as those who don't.

If you don't have a health care plan, or your plan won't pay for your Genentech product(s), we might be able to help. If you meet certain financial and medical standards, we can supply free medicine. This is done through the Genentech® Access to Care Foundation (GATCF).

For us to help, we need to look at, use and disclose your personally identifiable information (PII). Your health care provider and health care plan can disclose your PII to us only with your written authorization. By signing this authorization form, you are authorizing your health care provider and health care plan to release your PII to us, and authorizing us to disclose your PII as necessary to perform services for you. Once you sign this form and it is sent back to us, or submitted electronically by you or by your health care provider on your behalf, we can start to provide these services. You can choose not to agree to this authorization, however, please note that we cannot provide our services without it. This means you might need to pay for certain medications on your own.

PLEASE READ THROUGH THIS FORM CAREFULLY. IF YOU HAVE ANY QUESTIONS, TALK TO YOUR HEALTH CARE PROVIDER'S OFFICE OR CALL US AT THE PHONE NUMBER LISTED AT THE TOP OF THIS PAGE.

1 INFORMATION TO BE DISCLOSED OR USED

This signed form lets my health care providers and health care plans send my PII, and this form electronically, to Genentech Access Solutions and/or GATCF. This includes:

- All my health records relating to my treatment
- Information about my health care plan benefits
- The dollar balance left on the total of the lifetime payments covered by my health care plan policy (if this applies to my plan)
- Any information having a bearing on my health or my adherence to my treatment

All of the above is considered part of my PII. I know this could include information about:

- Sexually transmitted diseases
- Mental health conditions
- Genetic test results

2 WHO MAY SEE AND USE MY PII

My PII may be seen by Genentech Access Solutions and/or GATCF. These are programs sponsored by Genentech. Its address is 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. It may also be seen by anyone helping Genentech Access Solutions perform services, including Genentech employees and any of Genentech's partners, for the purpose of facilitating access to Genentech products. Genentech may share your PII with Sponsors, and/or their agents and affiliates, and your health care provider and health plan.

My PII may be used only in these ways:

- Helping with my health care plan coverage for Genentech products
- Applying to GATCF
- Determining eligibility for alternative forms of coverage and sources of funding
- Coordination of prescription fulfillment through a pharmacy
- Tracking my use of Genentech products
- For Genentech, or our partners' administrative purposes

3 NOTICES

This authorization and notice of release is in effect for 1 year from the date I signed it.

Once I sign this form, I know my PII might not be covered by any federal law that restricts the use and disclosure of my PII. There is no guarantee my PII might not be released to a third party. This third party might not need to follow the conditions of this authorization and notice of release.

I know I can refuse to sign this form. I may withdraw authorization at any time and for any reason. This won't affect the start or continuing of my treatment, the quality of my treatment, and will have no impact on my treatment by my health care provider. To withdraw it, I must send a written notice to Genentech. It can be sent by fax or by mail to the address on this page. This withdrawal goes into effect once it is received by Genentech. If I don't sign this form or if I withdraw my authorization, Genentech will not be able to help me with access to my Genentech product(s).

I understand that I, as the patient or signer, have a right to obtain a copy of this signed authorization and notice of release during the one year it is valid, and up to three years after it is signed.

4 DISTRIBUTION ACCEPTANCE

If I receive free product from GATCF, I will use Genentech products as my health care provider has prescribed them to me. I will not sell or distribute Genentech products. I understand it is unlawful to do this. I am responsible for ensuring any Genentech product is sent to a secure address when it is shipped to me. I know it is my duty to control any Genentech product while it stays in my possession.

This written notice must be signed, dated, and mailed, faxed, or electronically submitted to

Genentech Access Solutions
1 DNA Way, Mail Stop #858a
South San Francisco, CA 94080-4990

Fax: (866) 724-9412

5 SIGNATURE AND DATE (REQUIRED)

I have read this document or have had it explained to me. By signing this form, I know I am authorizing the release and disclosure of my PII as discussed in this authorization form. **Please fill in all information below. Be sure to sign and date this form. If you don't, it could hold up the process for helping you.**

You must sign and date here

_____ Signature of Patient or Legally Authorized Person

_____ Relationship to Patient

_____ Date Signed

You must print your name here

_____ Print Patient's Name

_____ Patient/Alternate Contact Address

If signing for the patient you must print your name here

_____ Legally Authorized Person/Alternate Contact Name

_____ Contact Phone

☐ OK to leave a detailed message*: I authorize Genentech Access Solutions/GATCF to leave a detailed message at the following number: _____

*I understand this message may include PII, including but not limited to, the name of the medication I have been prescribed, my doctor's name, and details regarding insurance coverage

6 FINANCIAL INFORMATION (GATCF ONLY)

TOTAL HOUSEHOLD INCOME FOR THE PREVIOUS CALENDAR YEAR: $ _____

Read the following attestation: I understand that to qualify for free medicine, GATCF has criteria that must be met, including income. I certify the above statement of my total annual household income for the previous calendar year is true, and I do not have the financial resources or insurance coverage to pay for Genentech products. I know that GATCF could ask me for a copy of my IRS 1040 form or other proof of income for the purpose of an audit. I agree to provide my financial documentation in a timely manner, if so requested. In addition, I will notify GATCF immediately if my insurance situation changes. Please note that GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the financial attestation is false or inaccurate. By signing this attestation, I certify that the above statement of my annual household income amount is true and accurate, to the best of my knowledge.

Sign and date here (Required for GATCF Enrollment)

_____ Signature of Patient or Legally Authorized Person

_____ Date Signed

7 AN OPTIONAL AND FREE PATIENT SUPPORT PROGRAM

I want to enroll in an optional and free patient support program from Genentech. I understand my PII is needed for me to be a part of this program. I also know my PII will be shared with Genentech Access Solutions and the patient support program. I may choose to be contacted by mail, email or phone. I understand my PII won't be shared outside of Genentech, or by its agents. I agree to let Genentech or its agents contact me in the future about this program.

The Genentech privacy policy can be found at Genentech-Access.com. I understand I do not have to sign this part of the form. It plays no role in getting my medicine. It is not part of receiving help from Genentech Access Solutions. I also know I may cancel this enrollment in the patient support program at any time. To cancel, I can call (877) 436-3683.

Preferred way to contact me (Please check the box that applies and fill in your information. You can check more than one box.):
☐ Email: _____ ☐ Phone Number: _____ Okay to leave a message? ☐ Yes ☐ No
☐ Address: _____

Choose to enroll by signing here

_____ Signature of Patient/Legally Authorized Person (You must sign here to enroll in the patient support program)

_____ Date Signed

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AUTORIZACIÓN DEL PACIENTE Y AVISO DE DIVULGACIÓN DE INFORMACIÓN (PAN)

LUCENTIS RANIBIZUMAB INJECTION | Access Solutions

Teléfono: (866) 724-9394 **Fax:** (866) 724-9412 **Genentech-Access.com/LUCENTIS**

ACS/091814/0027(1) 10/14

LUCENTIS Access Solutions es un programa gratuito de Genentech para usted.

Trabajamos para ayudarlo a pagar su producto de Genentech. Podemos ayudarlo de muchas maneras diferentes. Ayudamos a las personas que cuentan con un plan de salud y a quienes no lo tienen.

Si no tiene plan de salud, o si su plan no pagará por su(s) producto(s) de Genentech, es posible que podamos ayudarlo. Si cumple con ciertos estándares financieros y médicos, podemos proporcionarle el medicamento en forma gratuita. Esto se hace a través de la Genentech® Access to Care Foundation (GATCF).

Para ayudarlo, necesitamos ver, usar y revelar su información personal identificable (personally identifiable information, PII). Su proveedor de atención médica y su plan de salud pueden revelarnos su PII únicamente con su autorización por escrito. Al firmar este formulario de autorización, usted autoriza a su proveedor de atención médica y a su plan de salud a entregarnos su PII, y nos autoriza a revelar su PII según sea necesario para proporcionarle servicios. Una vez que firme este formulario y se nos envíe de regreso, o usted o su proveedor de atención médica en su nombre nos lo envíen electrónicamente, podemos empezar a proporcionarle estos servicios. Usted puede optar por no aceptar esta autorización, sin embargo, tenga en cuenta que no podemos proporcionarle nuestros servicios sin ella. Esto significa que podría ser necesario que pague ciertos medicamentos por su propia cuenta.

LEA CUIDADOSAMENTE ESTE FORMULARIO. SI TIENE PREGUNTAS, LLAME AL CONSULTORIO DE SU PROVEEDOR DE ATENCIÓN MÉDICA O LLÁMENOS AL NÚMERO TELEFÓNICO QUE APARECE EN LA PARTE SUPERIOR DE ESTA PÁGINA.

1 INFORMACIÓN QUE SE REVELARÁ O USARÁ

Este formulario firmado les permite a mis proveedores de atención médica y planes de salud enviar mi PII, y este formulario en forma electrónica, a Genentech Access Solutions y/o a la GATCF. Esto incluye:

- Todos mis registros médicos relacionados con mi tratamiento
- Información sobre los beneficios de mi plan de salud
- El saldo en dólares que queda del total de los pagos de por vida que cubre la póliza de mi plan de salud (si esto se aplica a mi plan)
- Toda información relacionada con mi salud o el cumplimiento de mi tratamiento

Todo lo mencionado arriba se considera parte de mi PII. Sé que esto podría incluir información sobre:

- Enfermedades de transmisión sexual
- Afecciones de salud mental
- Resultados de pruebas genéticas

2 QUIÉN PUEDE VER Y USAR MI PII

Mi PII puede ser vista por Genentech Access Solutions y/o la GATCF. Estos son programas que patrocina Genentech. Su dirección es 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. También puede ser vista por cualquier persona que ayude a Genentech Access Solutions en la prestación de servicios, lo que incluye a empleados de Genentech y a cualquier socio de Genentech, a los efectos de facilitar el acceso a los productos de Genentech. Genentech puede compartir su PII con los Patrocinadores, y/o sus agentes y afiliadas, y con su proveedor de atención médica y plan de salud.

Mi PII se puede usar solamente de las maneras siguientes:

- Ayudarme con la cobertura de mi plan de salud para productos de Genentech
- Presentar una solicitud a la GATCF
- Determinar la elegibilidad para formas de cobertura y fuentes de financiamiento alternativas
- Coordinación del surtido de recetas a través de una farmacia
- Rastrear mi uso de productos de Genentech
- Para fines administrativos de Genentech o de nuestros socios

3 AVISOS

Esta autorización y aviso de divulgación tiene vigencia durante 1 año a partir de la fecha en que la firmé.

Una vez que firme este formulario, sé que mi PII podría no estar cubierta por las leyes federales que restringen el uso y la divulgación de mi PII. No existe ninguna garantía de que mi PII no se revele a un tercero. Es posible que este tercero no necesite cumplir con las condiciones de esta autorización y aviso de divulgación.

Sé que puedo negarme a firmar este formulario. Puedo retirar la autorización en cualquier momento y por cualquier razón. Esto no afectará el inicio ni la continuación de mi tratamiento, tampoco afectará la calidad de mi tratamiento, ni tendrá efecto alguno en el tratamiento que me brinda mi proveedor de atención médica. Debo enviar un aviso por escrito a Genentech para retirarla. Puedo enviarlo por fax o por correo postal a la dirección que se muestra en esta página. Este retiro entra en vigencia una vez que Genentech lo recibe. Si no firmo este formulario o si retiro mi autorización, Genentech no podrá ayudarme con el acceso a mi(s) producto(s) de Genentech.

Comprendo que, como paciente o firmante, tengo derecho a obtener una copia de esta autorización y aviso de divulgación firmada durante el año en que tenga validez, y hasta tres años después de que se firme.

4 ACEPTACIÓN DE DISTRIBUCIÓN

Si recibo productos gratuitos de la GATCF, usaré los productos de Genentech como mi proveedor de atención médica me los recetó. No venderé o distribuiré los productos de Genentech. Entiendo que es ilegal hacerlo. Soy responsable de asegurarme de que cualquier producto de Genentech se envíe a una dirección segura cuando me hagan el envío. Sé que es mi deber controlar cualquier producto de Genentech mientras esté en mi poder.

Este aviso por escrito se debe firmar, fechar y enviar por correo postal, fax o en forma electrónica a:

Genentech Access Solutions
1 DNA Way, Mail Stop #858a
South San Francisco, CA 94080-4990

Fax: (866) 724-9412

5 FIRMA Y FECHA (OBLIGATORIAS)

He leído este documento o me lo han explicado. Al firmar este formulario, sé que estoy autorizando la divulgación y entrega de mi PII como se analiza en este formulario de autorización. **Complete toda la información a continuación. Asegúrese de firmar y fechar este formulario. Si no lo hace, se podría retrasar el proceso para brindarle ayuda.**

Debe firmar y colocar la fecha aquí

_____ _____ _____
Firma del Paciente o de la Persona Legalmente Autorizada | Relación con el Paciente | Fecha de la Firma

Debe poner aquí su nombre, en letra de imprenta

_____ _____
Nombre del Paciente, en Letra de Imprenta | Dirección del Paciente/Contacto Alternativo

Si firma por el paciente, debe poner aquí su nombre, en letra de imprenta

_____ _____
Nombre de la Persona Legalmente Autorizada/Nombre del Contacto Alternativo | Teléfono del Contacto

☐ Se puede dejar un mensaje detallado*: Autorizo a Genentech Access Solutions/la GATCF a dejar un mensaje detallado en el siguiente número: _____

*Comprendo que este mensaje puede incluir PII, lo cual comprende, pero no se limita a, el nombre del medicamento que se me recetó, el nombre de mi médico y detalles relativos a la cobertura de seguro

6 INFORMACIÓN FINANCIERA (GATCF ÚNICAMENTE)

INGRESOS FAMILIARES TOTALES CORRESPONDIENTES AL AÑO CALENDARIO PREVIO: $ _____

Lea el testimonio siguiente: Comprendo que para reunir los requisitos a fin de recibir medicamentos gratuitos, la GATCF tiene ciertos criterios que se deben cumplir, lo que incluye los ingresos. Certifico que mi declaración anterior de los ingresos familiares totales correspondientes al año calendario previo es verdadera, y que no cuento con recursos económicos ni cobertura de seguro para pagar los productos de Genentech. Sé que la GATCF podría solicitarme una copia de mi formulario 1040 del IRS u otra prueba de mis ingresos para propósitos de auditoría. Estoy de acuerdo con proporcionar en forma oportuna mis documentos financieros, si me los solicitan. Además, notificaré inmediatamente a la GATCF si cambia mi situación de seguro. Tenga en cuenta que la GATCF ejercerá todos los recursos legales apropiados, lo que incluye un juicio de indemnización por daños y perjuicios en litigio, en el caso de que la GATCF determine que esta certificación es falsa o que el testimonio financiero es falso o inexacto. Al firmar este testimonio, certifico que el monto de mis ingresos familiares anuales declarados arriba es verdadero y exacto, a mi leal saber y entender.

Firme y coloque la fecha aquí (Se requiere para la inscripción en la GATCF)

_____ _____
Firma del Paciente o de la Persona Legalmente Autorizada | Fecha de la Firma

7 UN PROGRAMA OPCIONAL Y GRATUITO DE ASISTENCIA AL PACIENTE

Deseo inscribirme en un programa opcional y gratuito de asistencia al paciente brindado por Genentech. Entiendo que se necesita mi PII para que pueda participar en este programa. También sé que se compartirá mi PII con Genentech Access Solutions y con el programa de asistencia al paciente. Puedo elegir que se me contacte por correo, correo electrónico o teléfono. Entiendo que mi PII no será compartida fuera de Genentech, ni por sus agentes. Acepto que Genentech o sus agentes se pongan en contacto conmigo en el futuro sobre este programa.

La política de privacidad de Genentech se puede encontrar en Genentech-Access.com. Entiendo que no tengo que firmar esta parte del formulario. No tiene ningún efecto a la hora de obtener mi medicamento. No forma parte de recibir asistencia de Genentech Access Solutions. También sé que puedo cancelar esta inscripción en el programa de asistencia al paciente en cualquier momento. Para cancelar, puedo llamar al (877) 436-3683.

Forma preferida de ponerse en contacto conmigo (Marque el casillero que corresponda y complete su información. Puede marcar más de un casillero.):

☐ Correo electrónico: _____ ☐ Número de teléfono: _____ ¿Se puede dejar un mensaje? ☐ Sí ☐ No

☐ Dirección: _____

Elija inscribirse firmando aquí

_____ _____
Firma del Paciente o de la Persona Legalmente Autorizada (Debe firmar aquí para inscribirse en el programa de asistencia al paciente) | Fecha de la Firma

LUCENTIS®, su logotipo y el logotipo de Access Solutions son marcas comerciales registradas de Genentech, Inc

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STATEMENT OF MEDICAL NECESSITY (SMN)
for LUCENTIS® (ranibizumab injection)

LUCENTIS® RANIBIZUMAB INJECTION

Access Solutions®

Phone: (866) 724-9394 Fax: (866) 724-9412 Genentech-Access.com/LUCENTIS

Please complete with a ballpoint pen.

SERVICES REQUESTED* (check all that apply)

☐ Benefits Investigation/Prior Authorization ☐ Appeals Support ☐ Co-pay Assistance
☐ GATCF† Patient Assistance ☐ GATCF Eligibility Screening

PATIENT

Last name* _____ First name* _____ Birth date* _____ Gender* ☐ Male ☐ Female
Street _____ City _____ State* _____ ZIP _____
Home phone (_____)_____ Work/cell phone (_____)_____ **OK to contact patient?** ☐ Yes ☐ No

INSURANCE

☐ **Insurance card attached (optional: see reverse for details)**

☐ HMO/EPO ☐ PPO ☐ POS ☐ Indemnity
☐ Medicare/Medicaid ☐ PBM ☐ Pending Medicaid ☐ No insurance

Primary insurance (PI) name _____
PI phone _____
PI subscriber name _____
PI subscriber ID # _____
Policy/group # _____

☐ HMO/EPO ☐ PPO ☐ POS ☐ Indemnity
☐ Medicare/Medicaid ☐ PBM ☐ Pending Medicaid ☐ No insurance

Secondary insurance (SI) name _____
SI phone _____
SI subscriber name _____
SI subscriber ID # _____
Policy/group # _____

DIAGNOSIS/TREATMENT

Primary Rt Lt	Secondary Rt Lt	Tertiary Rt Lt	ICD-9-CM
☐ ☐	☐ ☐	☐ ☐	**362.52** Exudative senile macular degeneration
☐ ☐	☐ ☐	☐ ☐	**362.83** Retinal edema
☐ ☐	☐ ☐	☐ ☐	**362.35** Central retinal vein occlusion
☐ ☐	☐ ☐	☐ ☐	**362.36** Venous tributary (branch) occlusion
☐ ☐	☐ ☐	☐ ☐	**Other** Specify by ICD-9-CM _____

Primary Rt Lt	Secondary Rt Lt	Tertiary Rt Lt	ICD-9-CM
☐ ☐	☐ ☐	☐ ☐	**362.07** Diabetic macular edema
☐ ☐	☐ ☐	☐ ☐	**250.50** Diabetes with ophthalmic manifestations, type 2 or unspecified type, not stated as uncontrolled
☐ ☐	☐ ☐	☐ ☐	**250.51** Diabetes with ophthalmic manifestations, type 1 [juvenile type], not stated as uncontrolled
☐ ☐	☐ ☐	☐ ☐	**250.52** Diabetes with ophthalmic manifestations, type 2 or unspecified type, uncontrolled
☐ ☐	☐ ☐	☐ ☐	**250.53** Diabetes with ophthalmic manifestations, type 1 [juvenile type], uncontrolled
☐ ☐	☐ ☐	☐ ☐	**362.01** Background diabetic retinopathy
☐ ☐	☐ ☐	☐ ☐	**362.02** Proliferative diabetic retinopathy
☐ ☐	☐ ☐	☐ ☐	**362.03** Nonproliferative diabetic retinopathy NOS
☐ ☐	☐ ☐	☐ ☐	**362.04** Mild nonproliferative diabetic retinopathy
☐ ☐	☐ ☐	☐ ☐	**362.05** Moderate nonproliferative diabetic retinopathy
☐ ☐	☐ ☐	☐ ☐	**362.06** Severe nonproliferative diabetic retinopathy

Eye(s) being treated (check all that apply). ☐ Rt ☐ Lt
Has patient started treatment? ☐ Yes ☐ No
Anticipated date of treatment: _____

PRESCRIPTION

LUCENTIS (ranibizumab injection): ☐ Drug allergies· _____ ☐ NKDA

DISPENSE: _____ vial(s) 0 05 mL of a 10-mg/mL solution
☐ SIG Inject 0 5 mg (0 05 mL) intravitreally monthly
☐ SIG Inject 0 5 mg (0 05 mL) intravitreally monthly x4 months then quarterly
☐ SIG Inject 0 5 mg (0 05 mL) intravitreally monthly x3 months then as needed (PRN)
☐ SIG _____ Refill _____ times

DISPENSE: _____ vial(s) 0 05 mL of a 6-mg/mL solution
☐ SIG Inject 0 3 mg (0 05 mL) intravitreally monthly
☐ SIG _____
Refill _____ times

Specialty pharmacy needed for dispensing ☐ Yes ☐ No (MD office will supply) Preferred specialty pharmacy _____
Ship to address (if different from office shown below) _____

PRESCRIBER

Prescriber's last name* _____ First name* _____
Practice name _____ Specialty _____
Street* _____ City* _____ State* _____ ZIP* _____
Phone (_____)_____ Fax (_____)_____
Prescriber Tax ID _____ Prescriber NPI‡ _____
DEA # _____ Group NPI _____ State license #* _____ PTAN§ _____
Reimbursement/clinical contact last name _____ First name _____
Reimbursement/clinical contact phone (_____)_____ Fax (_____)_____

UNAPPROVED USE WARNING Please read the FDA-approved label for LUCENTIS before prescribing If the indication for which you are prescribing LUCENTIS is not listed in the label, you are prescribing LUCENTIS for an "unapproved" use The fact that the use for which you are prescribing LUCENTIS is not listed in the FDA-approved label indicates that the FDA has not approved the efficacy, dosage amount or safety of LUCENTIS when used for such a use Nevertheless, GATCF will consider providing LUCENTIS for your patient with this admonition, based upon your medical order, within program requirements

By signing below, I certify that (a) the above therapy is medically necessary, (b) I have received the necessary authorization to release the above-referenced information and other protected health information (as defined in the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc , LUCENTIS Access Solutions and contracted dispensing pharmacy or other contractors for the purpose of seeking reimbursement, assisting in initiating or continuing therapy and/or the evaluation of the patient's eligibility for GATCF related to LUCENTIS, as a break in treatment would negatively impact the patient's therapeutic outcome, (c) I will not attempt to seek reimbursement for free or replacement product provided directly to the patient or for the dates of service for which free or replacement product was provided and (d) I appoint LUCENTIS Access Solutions solely to convey on my behalf to the pharmacy chosen by the above-named patient the prescription described herein

I agree to comply with the program guidelines as established by Genentech, Inc and understand that GATCF, at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of the information submitted I further understand that Genentech will provide vial replacement in a configuration that will create the least amount of wastage If applying for GATCF, I certify that this patient has no medical insurance coverage for the pharmaceutical identified above and is not eligible for other public health insurance programs

Sign and date here

Prescriber's Signature* _____ Date* _____
(Original or stamped signature required)

*Required field †Genentech® Access to Care Foundation ‡National Provider Identifier §Provider Transaction Access Number

STATEMENT OF MEDICAL NECESSITY (SMN)

PLEASE WRITE LEGIBLY AND COMPLETE ALL REQUIRED FIELDS (*) TO PREVENT DELAYS.

SERVICES REQUESTED

- Check the appropriate services requested LUCENTIS Access Solutions and/or GATCF cannot perform services without your specific authorization

DIAGNOSIS/TREATMENT

- Check the appropriate box to indicate which eye is affected, including any existing disease
- Be sure to indicate if the diagnosis is primary, secondary or tertiary by checking the box for the appropriate eye under the Primary, Secondary or Tertiary column next to the ICD-9-CM code
- If "Other" is checked, specify the ICD-9-CM code
- Please check either "yes" or "no." If the patient has not started treatment, enter the anticipated date of the first treatment

Note: These codes are not all inclusive. Commercial payers as well as Medicare and Medicaid may choose their own codes This guide is provided for informational purposes only Correct coding is the responsibility of the provider submitting a claim for the item or service Please check with the payer to verify codes and special billing requirements Genentech makes no representation or guarantee concerning reimbursement or coverage for any service or item

PRESCRIPTION

- Please ensure you complete all areas of the prescription portion clearly and completely
- LUCENTIS is available in vials of a 6-mg/mL or 10-mg/mL solution
- LUCENTIS can be dosed monthly using 0.3 mg (0.05 mL), 0 5 mg (0 05 mL), 0.5 mg (0 05 mL) monthly for 4 months, then quarterly, or 0 5 mg (0 05 mL) monthly for 3 months, then as needed (PRN)
- LUCENTIS should be refrigerated at 2-8° C (36-46° F) Please indicate where to send shipments (if different from the prescriber address) to ensure the drug will be stored appropriately

PRESCRIBER

- This form cannot be processed without an original or stamped signature

ATTACH TO COMPLETED SMN

- Attach a signed and dated Patient Authorization and Notice of Release of Information (PAN) form LUCENTIS Access Solutions and/or GATCF cannot work with the insurance plan on your patient's behalf without a signed and dated PAN form
- If the patient is insured, provide a front and back copy of the patient's drug card

REMINDER: This form cannot be processed without a prescriber's signature and date, as well as a signed and dated PAN form

Genentech-Access.com/LUCENTIS
Phone: (866) 724-9394 Fax: (866) 724-9412

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LUCENTIS® RANIBIZUMAB INJECTION
Access Solutions®

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PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION (PAN)

Phone: (800) 704-6614 **Fax:** (800) 704-6615 **LyticPortfolio.com**

ACS/092914/0047 10/14

The Genentech® Access to Care Foundation (GATCF) is a free program for you from Genentech.

We work to help you pay for your Genentech product. We can help in many different ways. We assist people who have a health care plan as well as those who don't.

If you don't have a health care plan, or your plan won't pay for your Genentech product(s), we might be able to help. If you meet certain financial and medical standards, we can supply free medicine. This is done through GATCF.

For us to help, we need to look at, use and disclose your personally identifiable information (PII). Your health care provider and health care plan can disclose your PII to us only with your written authorization. By signing this authorization form, you are authorizing your health care provider and health care plan to release your PII to us, and authorizing us to disclose your PII as necessary to perform services for you. Once you sign this form and it is sent back to us, or submitted electronically by you or by your health care provider on your behalf, we can start to provide these services. You can choose not to agree to this authorization, however, please note that we cannot provide our services without it. This means you might need to pay for certain medications on your own.

PLEASE READ THROUGH THIS FORM CAREFULLY. IF YOU HAVE ANY QUESTIONS, TALK TO YOUR HEALTH CARE PROVIDER'S OFFICE OR CALL US AT THE PHONE NUMBER LISTED AT THE TOP OF THIS PAGE.

1 INFORMATION TO BE DISCLOSED OR USED

This signed form lets my health care providers and health care plans send my PII, and this form electronically, to Genentech Access Solutions and/or GATCF. This includes:

- All my health records relating to my treatment
- Information about my health care plan benefits
- The dollar balance left on the total of the lifetime payments covered by my health care plan policy (if this applies to my plan)
- Any information having a bearing on my health or my adherence to my treatment

All of the above is considered part of my PII. I know this could include information about:

- Sexually transmitted diseases
- Mental health conditions
- Genetic test results

2 WHO MAY SEE AND USE MY PII

My PII may be seen by Genentech Access Solutions and/or GATCF. These are programs sponsored by Genentech. Its address is 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. It may also be seen by anyone helping Genentech Access Solutions perform services, including Genentech employees and any of Genentech's partners, for the purpose of facilitating access to Genentech products. Genentech may share your PII with Sponsors, and/or their agents and affiliates, and your health care provider and health plan.

My PII may be used only in these ways:

- Helping with my health care plan coverage for Genentech products
- Applying to GATCF
- Determining eligibility for alternative forms of coverage and sources of funding
- Coordination of prescription fulfillment through a pharmacy
- Tracking my use of Genentech products
- For Genentech, or our partners' administrative purposes

3 NOTICES

This authorization and notice of release is in effect for 1 year from the date I signed it.

Once I sign this form, I know my PII might not be covered by any federal law that restricts the use and disclosure of my PII. There is no guarantee my PII might not be released to a third party. This third party might not need to follow the conditions of this authorization and notice of release.

I know I can refuse to sign this form. I may withdraw authorization at any time and for any reason. This won't affect the start or continuing of my treatment, the quality of my treatment, and will have no impact on my treatment by my health care provider. To withdraw it, I must send a written notice to Genentech. It can be sent by fax or by mail to the address on this page. This withdrawal goes into effect once it is received by Genentech. If I don't sign this form or if I withdraw my authorization, Genentech will not be able to help me with access to my Genentech product(s).

I understand that I, as the patient or signer, have a right to obtain a copy of this signed authorization and notice of release during the one year it is valid, and up to three years after it is signed.

4 DISTRIBUTION ACCEPTANCE

If I receive free product from GATCF, I will use Genentech products as my health care provider has prescribed them to me. I will not sell or distribute Genentech products. I understand it is unlawful to do this. I am responsible for ensuring any Genentech product is sent to a secure address when it is shipped to me. I know it is my duty to control any Genentech product while it stays in my possession.

This written notice must be signed, dated, and mailed, faxed, or electronically submitted to

Genentech® Access to Care Foundation
1 DNA Way, Mail Stop #858a
South San Francisco, CA 94080-4990

Fax: (800) 704-6615

5 SIGNATURE AND DATE (REQUIRED)

I have read this document or have had it explained to me. By signing this form, I know I am authorizing the release and disclosure of my PII as discussed in this authorization form. **Please fill in all information below. Be sure to sign and date this form. If you don't, it could hold up the process for helping you.**

You must sign and date here

_____ _____ _____
Signature of Patient or Legally Authorized Person | Relationship to Patient | Date Signed

You must print your name here

_____ _____
Print Patient's Name | Patient/Alternate Contact Address

If signing for the patient you must print your name here

_____ _____
Legally Authorized Person/Alternate Contact Name | Contact Phone

☐ OK to leave a detailed message*: I authorize Genentech Access Solutions/GATCF to leave a detailed message at the following number: _____

*I understand this message may include PII, including but not limited to, the name of the medication I have been prescribed, my doctor's name, and details regarding insurance coverage

6 FINANCIAL INFORMATION (GATCF ONLY)

TOTAL HOUSEHOLD INCOME FOR THE PREVIOUS CALENDAR YEAR: $ _____

Read the following attestation: I understand that to qualify for free medicine, GATCF has criteria that must be met, including income. I certify the above statement of my total annual household income for the previous calendar year is true, and I do not have the financial resources or insurance coverage to pay for Genentech products. I know that GATCF could ask me for a copy of my IRS 1040 form or other proof of income for the purpose of an audit. I agree to provide my financial documentation in a timely manner, if so requested. In addition, I will notify GATCF immediately if my insurance situation changes. Please note that GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the financial attestation is false or inaccurate. By signing this attestation, I certify that the above statement of my annual household income amount is true and accurate, to the best of my knowledge.

Sign and date here (Required for GATCF Enrollment)

_____ _____
Signature of Patient or Legally Authorized Person | Date Signed

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AUTORIZACIÓN DEL PACIENTE Y AVISO DE DIVULGACIÓN DE INFORMACIÓN (PAN)

Teléfono: (800) 704-6614 **Fax:** (800) 704-6615 **LyticPortfolio.com**

ACS/091914/0035(1) 10/14

La Genentech® Access to Care Foundation (GATCF) es un programa gratuito de Genentech para usted.

Trabajamos para ayudarlo a pagar su producto de Genentech. Podemos ayudar de muchas maneras diferentes. Ayudamos a las personas que cuentan con un plan de salud y a quienes no lo tienen.

Si no tiene plan de salud, o si su plan no pagará por su(s) producto(s) de Genentech, es posible que podamos ayudarlo. Si cumple con ciertos estándares financieros y médicos, podemos proporcionarle el medicamento en forma gratuita. Esto se hace a través de la Genentech® Access to Care Foundation (GATCF).

Para ayudarlo, necesitamos ver, usar y revelar su información personal identificable (personally identifiable information, PII). Su proveedor de atención médica y su plan de salud pueden revelarnos su PII únicamente con su autorización por escrito. Al firmar este formulario de autorización, usted autoriza a su proveedor de atención médica y a su plan de salud a entregarnos su PII, y nos autoriza a revelar su PII según sea necesario para proporcionarle servicios. Una vez que firme este formulario y este se nos envíe de regreso, o usted o su proveedor de atención médica en su nombre nos lo envíen electrónicamente, podemos empezar a proporcionarle estos servicios. Usted puede optar por no acceder a esta autorización, sin embargo, tenga en cuenta que no podemos proporcionar nuestros servicios sin ella. Esto significa que podría ser necesario que pague ciertos medicamentos por su propia cuenta.

LEA CUIDADOSAMENTE ESTE FORMULARIO. SI TIENE PREGUNTAS, HABLE CON EL CONSULTORIO DE SU PROVEEDOR DE ATENCIÓN MÉDICA O LLÁMENOS AL NÚMERO TELEFÓNICO QUE APARECE EN LA PARTE SUPERIOR DE ESTA PÁGINA.

1 INFORMACIÓN QUE SE REVELARÁ O USARÁ

Este formulario firmado les permite a mis proveedores de atención médica y planes de salud enviar mi PII, y este formulario en forma electrónica, a Genentech Access Solutions y/o a la GATCF. Esto incluye:

- Todos mis registros médicos relacionados con mi tratamiento
- Información sobre los beneficios de mi plan de salud
- El saldo en dólares que queda del total de los pagos de por vida que cubre la póliza de mi plan de salud (si esto se aplica a mi plan)
- Toda información relacionada con mi salud o el cumplimiento de mi tratamiento

Todo lo mencionado arriba se considera parte de mi PII. Sé que esto podría incluir información sobre:

- Enfermedades de transmisión sexual
- Afecciones de salud mental
- Resultados de pruebas genéticas

ACS/091914/0035(1) 10/14

2 QUIÉN PUEDE VER Y USAR MI PII

Mi PII puede ser vista por Genentech Access Solutions o la GATCF. Estos son programas que patrocina Genentech. Su dirección es 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. También puede ser vista por cualquier persona que ayude a Genentech Access Solutions en la prestación de servicios, lo que incluye a empleados de Genentech y a cualquier socio de Genentech, a los efectos de facilitar el acceso a los productos de Genentech. Genentech puede compartir su PII con los Patrocinadores, y/o sus agentes y afiliadas, y con su proveedor de atención médica y plan de salud.

Mi PII se puede usar solamente de las maneras siguientes:

- Ayudarme con la cobertura de mi plan de salud para productos de Genentech
- Presentar una solicitud a la GATCF
- Determinar la elegibilidad para formas de cobertura y fuentes de financiamiento alternativas
- Coordinación del surtido de recetas a través de una farmacia
- Rastrear mi uso de productos de Genentech
- Para fines administrativos de Genentech o de nuestros socios

3 AVISOS

Esta autorización y aviso de divulgación tiene vigencia durante 1 año a partir de la fecha en que la firmé.

Una vez que firme este formulario, sé que mi PII podría no estar cubierta por las leyes federales que restringen el uso y la divulgación de mi PII. No existe ninguna garantía de que mi PII no se revele a un tercero. Es posible que este tercero no necesite cumplir con las condiciones de esta autorización y aviso de divulgación.

Sé que puedo negarme a firmar este formulario. Puedo retirar la autorización en cualquier momento y por cualquier razón. Esto no afectará el inicio ni la continuación de mi tratamiento, tampoco afectará la calidad de mi tratamiento, ni tendrá efecto alguno en el tratamiento que me brinda mi proveedor de atención médica. Debo enviar un aviso por escrito a Genentech para retirarla. Puedo enviarlo por fax o por correo postal a la dirección que se muestra en esta página. Este retiro entra en vigencia una vez que Genentech lo recibe. Si no firmo este formulario o si retiro mi autorización, Genentech no podrá ayudarme con el acceso a mi(s) producto(s) de Genentech.

Comprendo que, como paciente o firmante, tengo derecho a obtener una copia de esta autorización y aviso de divulgación firmada durante el año en que tenga validez, y hasta tres años después de que se firme.

4 ACEPTACIÓN DE DISTRIBUCIÓN

Si recibo productos gratuitos de la GATCF, usaré los productos de Genentech como mi proveedor de atención médica me los recetó. No venderé o distribuiré los productos de Genentech. Entiendo que es ilegal hacerlo. Soy responsable de asegurarme de que cualquier producto de Genentech se envíe a una dirección segura cuando me hagan el envío. Sé que es mi deber controlar cualquier producto de Genentech mientras esté en mi poder.

Este aviso por escrito se debe firmar, fechar y enviar por correo postal, fax o en forma electrónica a:

Genentech® Access to Care Foundation
PO Box 29064
Phoenix, AZ 85038

Fax: (866) 827-8188

5 FIRMA Y FECHA (OBLIGATORIAS)

He leído este documento o me lo han explicado. Al firmar este formulario, sé que estoy autorizando la divulgación y entrega de mi PII como se analiza en este formulario de autorización. **Complete toda la información a continuación. Asegúrese de firmar y fechar este formulario. Si no lo hace, se podría retrasar el proceso para brindarle ayuda.**

Debe firmar y colocar la fecha aquí

_____ _____ _____

Firma del Paciente o de la Persona Legalmente Autorizada | Relación con el Paciente | Fecha de la Firma

Debe poner aquí su nombre, en letra de imprenta

_____ _____

Nombre del Paciente, en Letra de Imprenta | Dirección del Paciente/Contacto Alternativo

Si firma por el paciente, debe poner aquí su nombre, en letra de imprenta

_____ _____

Nombre de la Persona Legalmente Autorizada/Nombre del Contacto Alternativo | Teléfono del Contacto

☐ Se puede dejar un mensaje detallado*: Autorizo a Genentech Access Solutions/la GATCF a dejar un mensaje detallado en el siguiente número: _____

*Comprendo que este mensaje puede incluir PII, lo cual comprende, pero no se limita a, el nombre del medicamento que se me recetó, el nombre de mi medico y detalles relativos a la cobertura de seguro

6 INFORMACIÓN FINANCIERA (GATCF ÚNICAMENTE)

INGRESOS FAMILIARES TOTALES CORRESPONDIENTES AL AÑO CALENDARIO PREVIO: $ _____

Lea el testimonio siguiente: Comprendo que para reunir los requisitos a fin de recibir medicamentos gratuitos, la GATCF tiene ciertos criterios que se deben cumplir, lo que incluye los ingresos. Certifico que mi declaración anterior de los ingresos familiares totales correspondientes al año calendario previo es verdadera, y que no cuento con recursos económicos ni cobertura de seguro para pagar los productos de Genentech. Sé que la GATCF podría solicitarme una copia de mi formulario 1040 del IRS u otra prueba de mis ingresos para propósitos de auditoría. Estoy de acuerdo con proporcionar en forma oportuna mis documentos financieros, si me los solicitan. Además, notificaré inmediatamente a la GATCF si cambia mi situación de seguro. Tenga en cuenta que la GATCF ejercerá todos los recursos legales apropiados, lo que incluye un juicio de indemnización por daños y perjuicios en litigio, en el caso de que la GATCF determine que esta certificación es falsa o que el testimonio financiero es falso o inexacto. Al firmar este testimonio, certifico que el monto de mis ingresos familiares anuales declarados arriba es verdadero y exacto, a mi leal saber y entender.

Firme y coloque la fecha aquí (Se requiere para la Inscripción en la GATCF)

_____ _____

Firma del Paciente o de la Persona Legalmente Autorizada | Fecha de la Firma

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STATEMENT OF MEDICAL NECESSITY (SMN)

Please write legibly and complete all required fields (*) to prevent delays

Phone: (800) 704-6614 Fax: (800) 704-6615 LyticPortfolio.com

SERVICES REQUESTED (Check all that apply)

☐ Genentech® Access to Care Foundation (GATCF) Patient Assistance

PATIENT

Last name* _____ First name*. _____ Birth date*· _____ Gender*: ☐ Male ☐ Female

Street. _____ City. _____ State*: _____ ZIP· _____

Home phone· (_____)_____ Work/cell phone. (_____)_____ Email: _____

Alternate contact last name. _____ First name. _____ Phone. (_____)_____

Relationship to patient. _____ OK to contact patient? ☐ Yes ☐ No

INSURANCE

Is patient currently insured? ☐ Yes ☐ No Current insurance: _____

Has treatment been denied? ☐ Yes ☐ No Is patient eligible for Medicaid? ☐ Yes ☐ No ☐ Pending

If pending, date application submitted· _____

DIAGNOSIS

DIAGNOSIS (highest level of specificity)*:

Primary ICD-9-CM code· _____ Description· _____

Secondary ICD-9-CM code _____ Description· _____

Place of administration*: ☐ Physician's office ☐ Hospital outpatient ☐ Hospital inpatient ☐ Other _____

SHIPPING INSTRUCTIONS

PRIMARY CONTACT NAME (REPLACEMENT VIALS ARE SHIPPED TO THIS PERSON)* _____

☐ Ship to prescriber's address ☐ Ship to different address (indicated below)

Facility/practice name· _____

Address (street address required, no PO boxes)· _____

City·_____ State. _____ ZIP:_____ Phone (_____)_____ Fax. (_____)_____

Facility DEA #*._____ Facility state license #*:_____

PRESCRIPTION

Please include infusion/injection records when faxing this form. Product dispensed (fill in appropriate information for all that apply)*·

Activase® (alteplase)

☐ 100-mg quantity (vials).____

☐ 50-mg quantity (vials) ____

Date of treatment·____

Cathflo® Activase

☐ 2-mg quantity (vials). ____

Date of treatment·____

TNKase® (tenecteplase)

☐ 50-mg kit: ____

Date of treatment·____

PRESCRIBER

Prescriber's last name*. _____ First name*· _____

Practice name. _____ Specialty. _____

Street*. _____ City*· _____ State*. _____ ZIP*. _____

Phone. (_____)_____ Fax· (_____)_____

Prescriber Tax ID· _____ Prescriber NPI*† _____

DEA #*: _____ Group NPI*. _____ State license #* _____ PTAN*‡. _____

Reimbursement/clinical contact last name· _____ First name. _____

Reimbursement/clinical contact phone (_____)_____ Fax (_____)_____

UNAPPROVED USE WARNING Please read the FDA-approved label for Activase, Cathflo Activase or TNKase before prescribing If the indication for which you are prescribing Activase, Cathflo Activase or TNKase is not listed in the label, you are prescribing Activase, Cathflo Activase or TNKase for an "unapproved" use The fact that the use for which you are prescribing Activase, Cathflo Activase or TNKase is not listed in the FDA-approved label indicates that the FDA has not approved the efficacy, dosage amount or safety of Activase, Cathflo Activase or TNKase when used for such a use Nevertheless, GATCF will consider providing Activase, Cathflo Activase or TNKase for your patient with this admonition, based upon your medical order, within program requirements

By signing below, I certify that (a) the above therapy is medically necessary, (b) I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc and contracted dispensing pharmacy or other contractors for the purpose of seeking reimbursement, assisting in initiating or continuing therapy and/or the evaluation of the patient's eligibility for GATCF related to Genentech products, as a break in treatment would negatively impact the patient's therapeutic outcome, (c) I will not attempt to seek reimbursement for free or replacement product provided directly to the patient or for the dates of service for which free or replacement product was provided and (d) I appoint GATCF solely to convey on my behalf to the pharmacy chosen by the above-named patient the prescription described herein

I agree to comply with the program guidelines as established by Genentech, Inc and understand that GATCF, at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of the information submitted

Prescriber's Signature* _____ Date* _____

*Required field †National Provider Identifier ‡Provider Transaction Access Number

STATEMENT OF MEDICAL NECESSITY (SMN)

Please write legibly and complete all required fields (*) to prevent delays

SERVICES REQUESTED

- Check the appropriate service requested The Genentech® Access to Care Foundation (GATCF) cannot offer assistance without your specific authorization

INSURANCE INFORMATION

- If the patient is insured, provide a front and back copy of the patient's drug card and the payer denial letter or policy showing non-coverage of therapy

DIAGNOSIS

- Enter the appropriate Diagnosis Code to the highest level of specificity using the appropriate 3-, 4- or 5-digit code

SHIPPING INSTRUCTIONS

- Identify the primary contact
- If the vials or kit should be shipped to a different facility or practice than the one listed in the Prescriber section, indicate that address, facility DEA number and facility state license number here

PRESCRIPTION

- Complete the dose field along with the dispense instructions

GATCF REQUIRED FIELDS

- All required fields are indicated with an asterisk (*)
- GATCF cannot process your SMN unless these fields are completed

ATTACH TO COMPLETED SMN

- Attach a signed and dated Patient Authorization and Notice of Release of Information (PAN) form GATCF cannot work on your patient's behalf without a signed and dated PAN form
- Include infusion/injection records

REMINDER: This form cannot be processed without a signed and dated PAN form.

Phone: (800) 704-6614 Fax: (800) 704-6615 LyticPortfolio.com

ACTIVASE® alteplase | cathflo® activase® (alteplase) | TNKase®

Genentech
A Member of the Roche Group

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Genentech® Access to Care Foundation (GATCF)
Insurance Attestation – Patient-Administered Drugs

Phone (888) 941-3331 - Fax (888) 929-3334

This form is required for each of your patient's insurances and will serve as proof that the patient's insurance company will not cover the prescribed PEGASYS® (peginterferon alfa-2a) therapy. Complete this form when the outcome for any situations listed below has been met.

Check ALL box(es) that apply to your patient and fax to GATCF at the number listed above.

- ☐ My office received an initial claim denial or Prior Authorization (PA) denial.
  - Date of initial claim denial or PA denial: _____/_____/_____
  - Reason for denial: _____
- ☐ My office has submitted for a first-level appeal.
  - Date appeal letter submitted: _____/_____/_____
- ☐ My office received a first-level appeal denial.
  - Date of appeal denial letter: _____/_____/_____
  - Reason for denial: _____
- ☐ My office received a peer-to-peer denial.
  - Date of review: _____/_____/_____
  - Reason for denial: _____
- ☐ My patient has met the daily/yearly CAP for insurance coverage.
  - Date CAP was met: _____/_____/_____
  - Date CAP reset: _____/_____/_____

PLEASE NOTE: If the patient's insurance denied coverage due to an administrative error, untimely filing or not following the insurance policy requirements, your patient does not meet GATCF insurance criteria. GATCF requires one level of appeal for patients to be considered rendered uninsured.

Please complete, sign and date the following statement. (REQUIRED)

Authorized HCP Signature (Required)*: _____ Date: _____

Print Physician First and Last Name: _____

Patient Insurance Company Name: _____

Print Patient's First and Last Name: _____

Patient's Date of Birth: _____

CERTIFICATION: By signing above, I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements.

I know GATCF could ask me for a copy of the patient's insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION (PAN)

PEGASYS® (Peginterferon alfa-2a) FOR INJECTION | Access Solutions®

Phone: (888) 941-3331 **Fax:** (888) 929-3334 **Genentech-Access.com/PEGASYS**

ACS/092914/0048 10/14

PEGASYS Access Solutions is a free program for you from Genentech.

We work to help you pay for your Genentech product. We can help in many different ways. We assist people who have a health care plan as well as those who don't.

If you don't have a health care plan, or your plan won't pay for your Genentech product(s), we might be able to help. If you meet certain financial and medical standards, we can supply free medicine. This is done through the Genentech® Access to Care Foundation (GATCF).

For us to help, we need to look at, use and disclose your personally identifiable information (PII). Your health care provider and health care plan can disclose your PII to us only with your written authorization. By signing this authorization form, you are authorizing your health care provider and health care plan to release your PII to us, and authorizing us to disclose your PII as necessary to perform services for you. Once you sign this form and it is sent back to us, or submitted electronically by you or by your health care provider on your behalf, we can start to provide these services. You can choose not to agree to this authorization, however, please note that we cannot provide our services without it. This means you might need to pay for certain medications on your own.

PLEASE READ THROUGH THIS FORM CAREFULLY. IF YOU HAVE ANY QUESTIONS, TALK TO YOUR HEALTH CARE PROVIDER'S OFFICE OR CALL US AT THE PHONE NUMBER LISTED AT THE TOP OF THIS PAGE.

1 INFORMATION TO BE DISCLOSED OR USED

This signed form lets my health care providers and health care plans send my PII, and this form electronically, to Genentech Access Solutions and/or GATCF. This includes:

- All my health records relating to my treatment
- Information about my health care plan benefits
- The dollar balance left on the total of the lifetime payments covered by my health care plan policy (if this applies to my plan)
- Any information having a bearing on my health or my adherence to my treatment

All of the above is considered part of my PII. I know this could include information about:

- Sexually transmitted diseases
- Mental health conditions
- Genetic test results

2 WHO MAY SEE AND USE MY PII

My PII may be seen by Genentech Access Solutions and/or GATCF. These are programs sponsored by Genentech. Its address is 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. It may also be seen by anyone helping Genentech Access Solutions perform services, including Genentech employees and any of Genentech's partners, for the purpose of facilitating access to Genentech products. Genentech may share your PII with Sponsors, and/or their agents and affiliates, and your health care provider and health plan.

My PII may be used only in these ways:

- Helping with my health care plan coverage for Genentech products
- Applying to GATCF
- Determining eligibility for alternative forms of coverage and sources of funding
- Coordination of prescription fulfillment through a pharmacy
- Tracking my use of Genentech products
- For Genentech, or our partners' administrative purposes

3 NOTICES

This authorization and notice of release is in effect for 1 year from the date I signed it.

Once I sign this form, I know my PII might not be covered by any federal law that restricts the use and disclosure of my PII. There is no guarantee my PII might not be released to a third party. This third party might not need to follow the conditions of this authorization and notice of release.

I know I can refuse to sign this form. I may withdraw authorization at any time and for any reason. This won't affect the start or continuing of my treatment, the quality of my treatment, and will have no impact on my treatment by my health care provider. To withdraw it, I must send a written notice to Genentech. It can be sent by fax or by mail to the address on this page. This withdrawal goes into effect once it is received by Genentech. If I don't sign this form or if I withdraw my authorization, Genentech will not be able to help me with access to my Genentech product(s).

I understand that I, as the patient or signer, have a right to obtain a copy of this signed authorization and notice of release during the one year it is valid, and up to three years after it is signed.

4 DISTRIBUTION ACCEPTANCE

If I receive free product from GATCF, I will use Genentech products as my health care provider has prescribed them to me. I will not sell or distribute Genentech products. I understand it is unlawful to do this. I am responsible for ensuring any Genentech product is sent to a secure address when it is shipped to me. I know it is my duty to control any Genentech product while it stays in my possession.

This written notice must be signed, dated, and mailed, faxed, or electronically submitted to

Genentech Access Solutions
1 DNA Way, Mail Stop #858a
South San Francisco, CA 94080-4990

Fax: (888) 929-3334

5 SIGNATURE AND DATE (REQUIRED)

I have read this document or have had it explained to me. By signing this form, I know I am authorizing the release and disclosure of my PII as discussed in this authorization form. **Please fill in all information below. Be sure to sign and date this form. If you don't, it could hold up the process for helping you.**

You must sign and date here

Signature of Patient or Legally Authorized Person _____ Relationship to Patient _____ Date Signed _____

You must print your name here

Print Patient's Name _____ Patient/Alternate Contact Address _____

If signing for the patient you must print your name here

Legally Authorized Person/Alternate Contact Name _____ Contact Phone _____

☐ OK to leave a detailed message*: I authorize Genentech Access Solutions/GATCF to leave a detailed message at the following number: _____

*I understand this message may include PII, including but not limited to, the name of the medication I have been prescribed, my doctor's name, and details regarding insurance coverage.

6 FINANCIAL INFORMATION (GATCF ONLY)

TOTAL HOUSEHOLD INCOME FOR THE PREVIOUS CALENDAR YEAR: $ _____

Read the following attestation: I understand that to qualify for free medicine, GATCF has criteria that must be met, including income. I certify the above statement of my total annual household income for the previous calendar year is true, and I do not have the financial resources or insurance coverage to pay for Genentech products. I know that GATCF could ask me for a copy of my IRS 1040 form or other proof of income for the purpose of an audit. I agree to provide my financial documentation in a timely manner, if so requested. In addition, I will notify GATCF immediately if my insurance situation changes. Please note that GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the financial attestation is false or inaccurate. By signing this attestation, I certify that the above statement of my annual household income amount is true and accurate, to the best of my knowledge.

Sign and date here (Required for GATCF Enrollment)

Signature of Patient or Legally Authorized Person _____ Date Signed _____

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AUTORIZACIÓN DEL PACIENTE Y AVISO DE DIVULGACIÓN DE INFORMACIÓN (PAN)

PEGASYS® (Peginterferon alfa-2a) FOR INJECTION | Access Solutions®

Teléfono: (888) 941-3331 **Fax:** (888) 929-3334 **Genentech-Access.com/PEGASYS**

ACS/091814/0029(1) 10/14

PEGASYS Access Solutions es un programa gratuito de Genentech para usted.

Trabajamos para ayudarlo a pagar su producto de Genentech. Podemos ayudar de muchas maneras diferentes. Ayudamos a las personas que cuentan con un plan de salud y a quienes no lo tienen.

Si no tiene plan de salud, o si su plan no pagará por su(s) producto(s) de Genentech, es posible que podamos ayudarlo. Si cumple con ciertos estándares financieros y médicos, podemos proporcionarle el medicamento en forma gratuita. Esto se hace a través de la Genentech® Access to Care Foundation (GATCF).

Para ayudarlo, necesitamos ver, usar y revelar su información personal identificable (personally identifiable information, PII). Su proveedor de atención médica y su plan de salud pueden revelarnos su PII únicamente con su autorización por escrito. Al firmar este formulario de autorización, usted autoriza a su proveedor de atención médica y a su plan de salud a entregarnos su PII, y nos autoriza a revelar su PII según sea necesario para proporcionarle servicios. Una vez que firme este formulario y este se nos envíe de regreso, o usted o su proveedor de atención médica en su nombre nos lo envíen electrónicamente, podemos empezar a proporcionarle estos servicios. Usted puede optar por no acceder a esta autorización, sin embargo, tenga en cuenta que no podemos proporcionar nuestros servicios sin ella. Esto significa que podría ser necesario que pague ciertos medicamentos por su propia cuenta.

LEA CUIDADOSAMENTE ESTE FORMULARIO. SI TIENE PREGUNTAS, HABLE CON EL CONSULTORIO DE SU PROVEEDOR DE ATENCIÓN MÉDICA O LLÁMENOS AL NÚMERO TELEFÓNICO QUE APARECE EN LA PARTE SUPERIOR DE ESTA PÁGINA.

1 INFORMACIÓN QUE SE REVELARÁ O USARÁ

Este formulario firmado les permite a mis proveedores de atención médica y planes de salud enviar mi PII, y este formulario en forma electrónica, a Genentech Access Solutions y/o a la GATCF. Esto incluye:

- Todos mis registros médicos relacionados con mi tratamiento
- Información sobre los beneficios de mi plan de salud
- El saldo en dólares que queda del total de los pagos de por vida que cubre la póliza de mi plan de salud (si esto se aplica a mi plan)
- Toda información relacionada con mi salud o el cumplimiento de mi tratamiento

Todo lo mencionado arriba se considera parte de mi PII. Sé que esto podría incluir información sobre:

- Enfermedades de transmisión sexual
- Afecciones de salud mental
- Resultados de pruebas genéticas

2 QUIÉN PUEDE VER Y USAR MI PII

Mi PII puede ser vista por Genentech Access Solutions y/o la GATCF. Estos son programas que patrocina Genentech. Su dirección es 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. También puede ser vista por cualquier persona que ayude a Genentech Access Solutions en la prestación de servicios, lo que incluye a empleados de Genentech y a cualquier socio de Genentech, a los efectos de facilitar el acceso a los productos de Genentech. Genentech puede compartir su PII con los Patrocinadores, y/o sus agentes y afiliadas, y con su proveedor de atención médica y plan de salud.

Mi PII se puede usar solamente de las maneras siguientes:

- Ayudarme con la cobertura de mi plan de salud para productos de Genentech
- Presentar una solicitud a la GATCF
- Determinar la elegibilidad para formas de cobertura y fuentes de financiamiento alternativas
- Coordinación del surtido de recetas a través de una farmacia
- Rastrear mi uso de productos de Genentech
- Para fines administrativos de Genentech o de nuestros socios

3 AVISOS

Esta autorización y aviso de divulgación tiene vigencia durante 1 año a partir de la fecha en que la firmé.

Una vez que firme este formulario, sé que mi PII podría no estar cubierta por las leyes federales que restringen el uso y la divulgación de mi PII. No existe ninguna garantía de que mi PII no se revele a un tercero. Es posible que este tercero no necesite cumplir con las condiciones de esta autorización y aviso de divulgación.

Sé que puedo negarme a firmar este formulario. Puedo retirar la autorización en cualquier momento y por cualquier razón. Esto no afectará el inicio ni la continuación de mi tratamiento, tampoco afectará la calidad de mi tratamiento, ni tendrá efecto alguno en el tratamiento que me brinda mi proveedor de atención médica. Debo enviar un aviso por escrito a Genentech para retirarla. Puedo enviarlo por fax o por correo postal a la dirección que se muestra en esta página. Este retiro entra en vigencia una vez que Genentech lo recibe. Si no firmo este formulario o si retiro mi autorización, Genentech no podrá ayudarme con el acceso a mi(s) producto(s) de Genentech.

Comprendo que, como paciente o firmante, tengo derecho a obtener una copia de esta autorización y aviso de divulgación firmada durante el año en que tenga validez, y hasta tres años después de que se firme.

4 ACEPTACIÓN DE DISTRIBUCIÓN

Si recibo productos gratuitos de la GATCF, usaré los productos de Genentech como mi proveedor de atención médica me los recetó. No venderé o distribuiré los productos de Genentech. Entiendo que es ilegal hacerlo. Soy responsable de asegurarme de que cualquier producto de Genentech se envíe a una dirección segura cuando me hagan el envío. Sé que es mi deber controlar cualquier producto de Genentech mientras esté en mi poder.

Este aviso por escrito se debe firmar, fechar y enviar por correo postal, fax o en forma electrónica a:

Genentech Access Solutions
1 DNA Way, Mail Stop #858a
South San Francisco, CA 94080-4990

Fax: (888) 929-3334

5 FIRMA Y FECHA (OBLIGATORIAS)

He leído este documento o me lo han explicado. Al firmar este formulario, sé que estoy autorizando la divulgación y entrega de mi PII como se analiza en este formulario de autorización. **Complete toda la información a continuación. Asegúrese de firmar y fechar este formulario. Si no lo hace, se podría retrasar el proceso para brindarle ayuda.**

Debe firmar y colocar la fecha aquí

_____ _____ _____
Firma del Paciente o de la Persona Legalmente Autorizada | Relación con el Paciente | Fecha de la Firma

Debe poner aquí su nombre, en letra de imprenta

_____ _____
Nombre del Paciente, en Letra de Imprenta | Dirección del Paciente/Contacto Alternativo

Si firma por el paciente, debe poner aquí su nombre, en letra de imprenta

_____ _____
Nombre de la Persona Legalmente Autorizada/Nombre del Contacto Alternativo | Teléfono del Contacto

☐ Se puede dejar un mensaje detallado*: Autorizo a Genentech Access Solutions/la GATCF a dejar un mensaje detallado en el siguiente número: _____

*Comprendo que este mensaje puede incluir PII, lo cual comprende, pero no se limita a, el nombre del medicamento que se me recetó, el nombre de mi médico y detalles relativos a la cobertura de seguro

6 INFORMACIÓN FINANCIERA (GATCF ÚNICAMENTE)

INGRESOS FAMILIARES TOTALES CORRESPONDIENTES AL AÑO CALENDARIO PREVIO: $ _____

Lea el testimonio siguiente: Comprendo que para reunir los requisitos a fin de recibir medicamentos gratuitos, la GATCF tiene ciertos criterios que se deben cumplir, lo que incluye los ingresos. Certifico que mi declaración anterior de los ingresos familiares totales correspondientes al año calendario previo es verdadera, y que no cuento con recursos económicos ni cobertura de seguro para pagar los productos de Genentech. Sé que la GATCF podría solicitarme una copia de mi formulario 1040 del IRS u otra prueba de mis ingresos para propósitos de auditoría. Estoy de acuerdo con proporcionar en forma oportuna mis documentos financieros, si me los solicitan. Además, notificaré inmediatamente a la GATCF si cambia mi situación de seguro. Tenga en cuenta que la GATCF ejercerá todos los recursos legales apropiados, lo que incluye un juicio de indemnización por daños y perjuicios en litigio, en el caso de que la GATCF determine que esta certificación es falsa o que el testimonio financiero es falso o inexacto. Al firmar este testimonio, certifico que el monto de mis ingresos familiares anuales declarados arriba es verdadero y exacto, a mi leal saber y entender.

Firme y coloque la fecha aquí (Se requiere para la Inscripción en la GATCF)

_____ _____
Firma del Paciente o de la Persona Legalmente Autorizada | Fecha de la Firma

PEGASYS®, su logotipo y el logotipo de Access Solutions son marcas comerciales registradas de Genentech, Inc

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GENENTECH® ACCESS TO CARE FOUNDATION (GATCF)
STATEMENT OF MEDICAL NECESSITY (SMN)

PEGASYS® (Peginterferon alfa-2a) FOR INJECTION | Access Solutions®

Please write legibly and complete all required fields (*) to prevent delays.

Phone: (888) 941-3331 Fax: (888) 929-3334 Genentech-Access.com/PEGASYS

PATIENT

Last name*: _____ First name*: _____ Birth date*: _____ Gender*: ☐ Male ☐ Female
Street: _____ City: _____ State*: _____ ZIP: _____
Home phone: (_____)_____ Work/cell phone: (_____)_____ Email: _____
Alternate contact last name: _____ First name: _____ Phone. (_____)_____
Relationship to patient: _____ OK to contact patient? ☐ Yes ☐ No

INSURANCE

Is patient currently insured? ☐ Yes ☐ No Current insurance: _____
Has treatment been denied? ☐ Yes ☐ No Is patient eligible for Medicaid? ☐ Yes ☐ No ☐ Pending
If pending, date application submitted: _____

DIAGNOSIS/TREATMENT

DIAGNOSIS (highest level of specificity)*: ☐ Hepatitis C (070.54) ☐ Hepatitis B (070.32)
☐ Other: Specify by ICD-9-CM: _____ ☐ HCV/HIV Co-infection

Genotype: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Prescription type: ☐ New start ☐ Continuing therapy ☐ Restart therapy
Therapy type: ☐ Mono ☐ Dual ☐ Triple
Duration of therapy: ☐ 12 weeks ☐ 24 weeks ☐ 48 weeks ☐ 24-48 weeks, depending on viral response ☐ Other: _____
Has patient started treatment? ☐ Yes ☐ No Anticipated date of treatment: _____

PRESCRIPTION

PEGASYS® (peginterferon alfa-2a) for injection

☐ 180 mcg/0 5 mL **PEGASYS ProClick™**
☐ 135 mcg/0 5 mL **PEGASYS ProClick**

SIG: ☐ Inject _____mcg/SubQ weekly

Dispense (months): ☐ 1 ☐ 2 ☐ 3
Refills: _____

☐ 180 mcg/0 5 mL **prefilled syringe**
☐ 180 mcg/1 mL **vial**

SIG: ☐ Inject _____ mcg/SubQ weekly

Dispense (months): ☐ 1 ☐ 2 ☐ 3
Refills: _____

COPEGUS® (ribavirin, USP) 200 mg **tablets**

SIG: ☐ _____mg BID
SIG: ☐ _____mg q AM and _____ q PM

Dispense (months): ☐ 1 ☐ 2 ☐ 3
Refills: _____

ACQUISITION

Shipping location*: ☐ Patient ☐ Prescriber ☐ Other: _____

PRESCRIBER

Prescriber's last name*: _____ First name*: _____
Practice name: _____ Specialty: _____
Street*: _____ City*: _____ State*: _____ ZIP*: _____
Phone: (_____)_____ Fax: (_____)_____
State license #*: _____
Reimbursement/clinical contact last name: _____ First name: _____
Reimbursement/clinical contact phone: (____)_____ Fax: (_____)_____

UNAPPROVED USE WARNING Please read the FDA-approved labels for PEGASYS and COPEGUS before prescribing If the indication for which you are prescribing PEGASYS and/or COPEGUS is not listed in the label, you are prescribing PEGASYS and/or COPEGUS for an "unapproved" use The fact that the use for which you are prescribing PEGASYS and/or COPEGUS is not listed in the FDA-approved label indicates that the FDA has not approved the efficacy, dosage amount or safety of PEGASYS and/or COPEGUS when used for such a use Nevertheless, GATCF will consider providing PEGASYS and/or COPEGUS for your patient with this admonition, based upon your medical order, within program requirements

By signing below, I certify that (a) the above therapy is medically necessary, (b) I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc , PEGASYS Access Solutions and contracted dispensing pharmacy or other contractors for the purpose of assisting in initiating or continuing therapy and/or the evaluation of the patient's eligibility for GATCF related to Genentech products, as a break in treatment would negatively impact the patient's therapeutic outcome and (c) I will not attempt to seek reimbursement for free or replacement product provided directly to the patient or for the dates of service for which free or replacement product was provided

I agree to comply with the program guidelines as established by Genentech, Inc and understand that GATCF, at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of the information submitted I further understand that Genentech will provide vial replacement in a configuration that will create the least amount of wastage

Sign and date here

Prescriber's Signature* _____ Date* _____
(Original signature required This form cannot be processed without a prescriber's signature)

*Required field

GENENTECH® ACCESS TO CARE FOUNDATION (GATCF) STATEMENT OF MEDICAL NECESSITY (SMN)

Please write legibly and complete all required fields (*) to prevent delays

INSURANCE INFORMATION

- If the patient is insured, provide a front and back copy of the patient's drug card, if available If you already have a denial, please provide the GATCF Insurance Attestation form

DIAGNOSIS/TREATMENT

- Check the appropriate diagnosis code
- If "Other" is checked, provide the ICD-9-CM code to the highest specificity available
- Give information on the genotype using the checkboxes provided

PRESCRIPTION

Please indicate the prescribed therapy

- Complete the dispense, refill and dose fields Complete SIG fields only for PEGASYS® (peginterferon alfa-2a) for injection prefilled syringe/vial or COPEGUS® (ribavirin, USP) prescriptions

REQUIRED FIELDS

- All required fields are indicated with an asterisk (*)
- PEGASYS Access Solutions and/or GATCF cannot process your SMN unless these fields are completed

ATTACH TO COMPLETED SMN

- Attach a signed and dated Patient Authorization and Notice of Release of Information (PAN) form PEGASYS Access Solutions and/or GATCF cannot work on your patient's behalf without a signed and dated PAN form
- Providing additional documents or information with this form (other than what is requested) will delay processing

REMINDER: This form cannot be processed without a prescriber's signature and date, as well as a signed and dated PAN form

Genentech-Access.com/PEGASYS
Phone: (888) 941-3331 Fax: (888) 929-3334

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Genentech® Access to Care Foundation (GATCF)
Confirmation of Infusion or Injection

Phone (800) 530-3083 - Fax (877) 428-2326

This completed document is required to participate in the Genentech Access to Care Foundation (GATCF) free PERJETA® (pertuzumab) program. This form is available online via My Patient Solutions™ for applicable brands*. Link to My Patient Solutions directly from Genentech-Access.com/PERJETA to enroll and manage your patients online.

Instructions: *All fields required.* Complete this form after each infusion/injection and fax completed form to GATCF at the number listed above or submit through My Patient Solutions.

Date of Service:	Amount Infused/Injected:	Date of Service:	Amount Infused/Injected:
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg

Please complete, sign and date the following statement. (REQUIRED)

Print Patient Name (Required): _____

Patient's Date of Birth (Required): _____

Authorized HCP Signature (Required)†: _____

Date of Signature (Required): _____

Next Scheduled Infusion (if applicable): _____

CERTIFICATION: By signing above, I certify that all information on this form is correct, and this patient has been infused/injected with product listed above. I know that GATCF could ask me for a copy of the patient's infusion/injection records for the purpose of an audit. I agree to provide a copy of the patient's infusion/injection records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the Confirmation of Infusion or Injection is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*Only BioOncology products, Rheumatology products and XOLAIR are supported by My Patient Solutions.
†The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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Genentech® Access to Care Foundation (GATCF)
Insurance Attestation – HCP Administered Drugs

Phone (800) 530-3083 - Fax (877) 428-2326

This form is required for each of your patient's insurances and will serve as proof that the patient's insurance company will not cover the prescribed PERJETA® (pertuzumab) therapy. This form should be completed once you have the outcome of the first level of appeal.

Check ALL box(es) that apply to your patient and fax to GATCF at the number listed above.

☐ My office received a first-level appeal denial and the initial claim or Prior Authorization (PA) denial is upheld.

Date of initial claim or PA denial: ____/____/____

Reason for initial claim or PA denial:_____

Date of first-level appeal denial: ____/____/____

Reason for first-level appeal denial:_____

☐ My office received a recoupment for date of service:____/____/____

Date of recoupment letter:____/____/____

Reason for recoupment:_____

☐ My office received a peer-to-peer denial.

Date of review:____/____/____

Reason denial:_____

☐ My patient has met the daily/yearly CAP for insurance coverage.

Date CAP was met:____/____/____

Date CAP reset:____/____/____

PLEASE NOTE: If the patient's insurance denied coverage due to an administrative error, untimely filing or not following the insurance policy requirements, your patient does not meet GATCF insurance criteria. GATCF requires one level of appeal for patients to be considered rendered uninsured.

Please complete, sign and date the following statement. (REQUIRED)

Authorized HCP Signature (Required): _____Date:_____

Print Physician First and Last Name: _____

Patient Insurance Company Name: _____

Print Patient's First and Last Name: _____

Patient's Date of Birth: _____

CERTIFICATION: By signing above, I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements.

I know GATCF could ask me for a copy of the patient's insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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Genentech® Access to Care Foundation (GATCF)
Insurance Attestation – Patient-Administered Drugs

Phone (800) 690-3023 - Fax (800) 963-1792

This form is required for each of your patient's insurances and will serve as proof that the patient's insurance company will not cover the prescribed Pulmozyme® (dornase alfa) Inhalation Solution therapy. Complete this form when the outcome for any situations listed below has been met.

Check ALL box(es) that apply to your patient and fax to GATCF at the number listed above.

- ☐ My office received an initial claim denial or Prior Authorization (PA) denial.
  - Date of initial claim denial or PA denial: _____/_____/_____
  - Reason for denial:_____
- ☐ My office has submitted for a first-level appeal.
  - Date appeal letter submitted:____/____/____
- ☐ My office received a first-level appeal denial.
  - Date of appeal denial letter:____/____/____
  - Reason for denial:_____
- ☐ My office received a peer-to-peer denial.
  - Date of review:____/____/____
  - Reason for denial:_____
- ☐ My patient has met the daily/yearly CAP for insurance coverage.
  - Date CAP was met:_____/____/____
  - Date CAP reset:_____/____/____

PLEASE NOTE: If the patient's insurance denied coverage due to an administrative error, untimely filing or not following the insurance policy requirements, your patient does not meet GATCF insurance criteria. GATCF requires one level of appeal for patients to be considered rendered uninsured.

Please complete, sign and date the following statement. (REQUIRED)

Authorized HCP Signature (Required)*: _____ Date:_____

Print Physician First and Last Name: _____

Patient Insurance Company Name: _____

Print Patient's First and Last Name: _____

Patient's Date of Birth: _____

CERTIFICATION: By signing above, I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements.

I know GATCF could ask me for a copy of the patient's insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION (PAN)

Pulmozyme® dornase alfa INHALATION SOLUTION | Access Solutions®

Phone: (800) 690-3023 **Fax:** (800) 963-1792 **Genentech-Access.com/Pulmozyme**

ACS/093014/0052 10/14

Pulmozyme Access Solutions is a free program for you from Genentech.

We work to help you pay for your Genentech product. We can help in many different ways. We assist people who have a health care plan as well as those who don't.

If you don't have a health care plan, or your plan won't pay for your Genentech product(s), we might be able to help. If you meet certain financial and medical standards, we can supply free medicine. This is done through the Genentech® Access to Care Foundation (GATCF).

For us to help, we need to look at, use and disclose your personally identifiable information (PII). Your health care provider and health care plan can disclose your PII to us only with your written authorization. By signing this authorization form, you are authorizing your health care provider and health care plan to release your PII to us, and authorizing us to disclose your PII as necessary to perform services for you. Once you sign this form and it is sent back to us, or submitted electronically by you or by your health care provider on your behalf, we can start to provide these services. You can choose not to agree to this authorization, however, please note that we cannot provide our services without it. This means you might need to pay for certain medications on your own.

PLEASE READ THROUGH THIS FORM CAREFULLY. IF YOU HAVE ANY QUESTIONS, TALK TO YOUR HEALTH CARE PROVIDER'S OFFICE OR CALL US AT THE PHONE NUMBER LISTED AT THE TOP OF THIS PAGE.

1 INFORMATION TO BE DISCLOSED OR USED

This signed form lets my health care providers and health care plans send my PII, and this form electronically, to Genentech Access Solutions and/or GATCF. This includes:

- All my health records relating to my treatment
- Information about my health care plan benefits
- The dollar balance left on the total of the lifetime payments covered by my health care plan policy (if this applies to my plan)
- Any information having a bearing on my health or my adherence to my treatment

All of the above is considered part of my PII. I know this could include information about:

- Sexually transmitted diseases
- Mental health conditions
- Genetic test results

2 WHO MAY SEE AND USE MY PII

My PII may be seen by Genentech Access Solutions and/or GATCF. These are programs sponsored by Genentech. Its address is 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. It may also be seen by anyone helping Genentech Access Solutions perform services, including Genentech employees and any of Genentech's partners, for the purpose of facilitating access to Genentech products. Genentech may share your PII with Sponsors, and/or their agents and affiliates, and your health care provider and health plan.

My PII may be used only in these ways:

- Helping with my health care plan coverage for Genentech products
- Applying to GATCF
- Determining eligibility for alternative forms of coverage and sources of funding
- Coordination of prescription fulfillment through a pharmacy
- Tracking my use of Genentech products
- For Genentech, or our partners' administrative purposes

3 NOTICES

This authorization and notice of release is in effect for 1 year from the date I signed it.

Once I sign this form, I know my PII might not be covered by any federal law that restricts the use and disclosure of my PII. There is no guarantee my PII might not be released to a third party. This third party might not need to follow the conditions of this authorization and notice of release.

I know I can refuse to sign this form. I may withdraw authorization at any time and for any reason. This won't affect the start or continuing of my treatment, the quality of my treatment, and will have no impact on my treatment by my health care provider. To withdraw it, I must send a written notice to Genentech. It can be sent by fax or by mail to the address on this page. This withdrawal goes into effect once it is received by Genentech. If I don't sign this form or if I withdraw my authorization, Genentech will not be able to help me with access to my Genentech product(s).

I understand that I, as the patient or signer, have a right to obtain a copy of this signed authorization and notice of release during the one year it is valid, and up to three years after it is signed.

4 DISTRIBUTION ACCEPTANCE

If I receive free product from GATCF, I will use Genentech products as my health care provider has prescribed them to me. I will not sell or distribute Genentech products. I understand it is unlawful to do this. I am responsible for ensuring any Genentech product is sent to a secure address when it is shipped to me. I know it is my duty to control any Genentech product while it stays in my possession.

This written notice must be signed, dated, and mailed, faxed, or electronically submitted to

Genentech Access Solutions
1 DNA Way, Mail Stop #858a
South San Francisco, CA 94080-4990

Fax: (800) 963-1792

5 SIGNATURE AND DATE (REQUIRED)

I have read this document or have had it explained to me. By signing this form, I know I am authorizing the release and disclosure of my PII as discussed in this authorization form. **Please fill in all information below. Be sure to sign and date this form. If you don't, it could hold up the process for helping you.**

You must sign and date here

_____ _____ _____

Signature of Patient or Legally Authorized Person | Relationship to Patient | Date Signed

You must print your name here

_____ _____

Print Patient's Name | Patient/Alternate Contact Address

If signing for the patient you must print your name here

_____ _____

Legally Authorized Person/Alternate Contact Name | Contact Phone

☐ OK to leave a detailed message*: I authorize Genentech Access Solutions/GATCF to leave a detailed message at the following number: _____

*I understand this message may include PII, including but not limited to, the name of the medication I have been prescribed, my doctor's name, and details regarding insurance coverage

6 FINANCIAL INFORMATION (GATCF ONLY)

TOTAL HOUSEHOLD INCOME FOR THE PREVIOUS CALENDAR YEAR: $ _____

Read the following attestation: I understand that to qualify for free medicine, GATCF has criteria that must be met, including income. I certify the above statement of my total annual household income for the previous calendar year is true, and I do not have the financial resources or insurance coverage to pay for Genentech products. I know that GATCF could ask me for a copy of my IRS 1040 form or other proof of income for the purpose of an audit. I agree to provide my financial documentation in a timely manner, if so requested. In addition, I will notify GATCF immediately if my insurance situation changes. Please note that GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the financial attestation is false or inaccurate. By signing this attestation, I certify that the above statement of my annual household income amount is true and accurate, to the best of my knowledge.

Sign and date here (Required for GATCF Enrollment)

_____ _____

Signature of Patient or Legally Authorized Person | Date Signed

7 AN OPTIONAL AND FREE PATIENT SUPPORT PROGRAM

I want to enroll in an optional and free patient support program from Genentech. I understand my PII is needed for me to be a part of this program. I also know my PII will be shared with Genentech Access Solutions and the patient support program. I may choose to be contacted by mail, email or phone. I understand my PII won't be shared outside of Genentech, or by its agents. I agree to let Genentech or its agents contact me in the future about this program.

The Genentech privacy policy can be found at Genentech-Access.com. I understand I do not have to sign this part of the form. It plays no role in getting my medicine. It is not part of receiving help from Genentech Access Solutions. I also know I may cancel this enrollment in the patient support program at any time. To cancel, I can call (877) 436-3683.

Preferred way to contact me (Please check the box that applies and fill in your information. You can check more than one box.):

☐ Email: _____ ☐ Phone Number: _____ Okay to leave a message? ☐ Yes ☐ No

☐ Address: _____

Choose to enroll by signing here

_____ _____

Signature of Patient/Legally Authorized Person (You must sign here to enroll in the patient support program) | Date Signed

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AUTORIZACIÓN DEL PACIENTE Y AVISO DE DIVULGACIÓN DE INFORMACIÓN (PAN)

Pulmozyme® dornase alfa | Access Solutions®

Teléfono: (800) 690-3023 **Fax:** (800) 963-1792 **Genentech-Access.com/Pulmozyme**

ACS/091814/0030(1) 10/14

Pulmozyme Access Solutions es un programa gratuito de Genentech para usted.

Trabajamos para ayudarlo a pagar su producto de Genentech. Podemos ayudarlo de muchas maneras diferentes. Ayudamos a las personas que cuentan con un plan de salud y a quienes no lo tienen.

Si no tiene plan de salud, o si su plan no pagará por su(s) producto(s) de Genentech, es posible que podamos ayudarlo. Si cumple con ciertos estándares financieros y médicos, podemos proporcionarle el medicamento en forma gratuita. Esto se hace a través de la Genentech® Access to Care Foundation (GATCF).

Para ayudarlo, necesitamos ver, usar y revelar su información personal identificable (personally identifiable information, PII). Su proveedor de atención médica y su plan de salud pueden revelarnos su PII únicamente con su autorización por escrito. Al firmar este formulario de autorización, usted autoriza a su proveedor de atención médica y a su plan de salud a entregarnos su PII, y nos autoriza a revelar su PII según sea necesario para proporcionarle servicios. Una vez que firme este formulario y este se nos envíe de regreso, o usted o su proveedor de atención médica en su nombre nos lo envíen electrónicamente, podemos empezar a proporcionarle estos servicios. Usted puede optar por no acceder a esta autorización, sin embargo, tenga en cuenta que no podemos proporcionarle nuestros servicios sin ella. Esto significa que podría ser necesario que pague ciertos medicamentos por su propia cuenta.

LEA CUIDADOSAMENTE ESTE FORMULARIO. SI TIENE PREGUNTAS, HABLE CON EL CONSULTORIO DE SU PROVEEDOR DE ATENCIÓN MÉDICA O LLÁMENOS AL NÚMERO TELEFÓNICO QUE APARECE EN LA PARTE SUPERIOR DE ESTA PÁGINA.

1 INFORMACIÓN QUE SE REVELARÁ O USARÁ

Este formulario firmado les permite a mis proveedores de atención médica y planes de salud enviar mi PII, y este formulario en forma electrónica, a Genentech Access Solutions y/o a la GATCF. Esto incluye:

- Todos mis registros médicos relacionados con mi tratamiento
- Información sobre los beneficios de mi plan de salud
- El saldo en dólares que queda del total de los pagos de por vida que cubre la póliza de mi plan de salud (si esto se aplica a mi plan)
- Toda información relacionada con mi salud o el cumplimiento de mi tratamiento

Todo lo mencionado arriba se considera parte de mi PII. Sé que esto podría incluir información sobre:

- Enfermedades de transmisión sexual
- Afecciones de salud mental
- Resultados de pruebas genéticas

2 QUIÉN PUEDE VER Y USAR MI PII

Mi PII puede ser vista por Genentech Access Solutions y/o la GATCF. Estos son programas que patrocina Genentech. Su dirección es 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. También puede ser vista por cualquier persona que ayude a Genentech Access Solutions en la prestación de servicios, lo que incluye a empleados de Genentech y a cualquier socio de Genentech, a los efectos de facilitar el acceso a los productos de Genentech. Genentech puede compartir su PII con los Patrocinadores, y/o sus agentes y afiliadas, y con su proveedor de atención médica y plan de salud.

Mi PII se puede usar solamente de las maneras siguientes:

- Ayudarme con la cobertura de mi plan de salud para productos de Genentech
- Presentar una solicitud a la GATCF
- Determinar la elegibilidad para formas de cobertura y fuentes de financiamiento alternativas
- Coordinación del surtido de recetas a través de una farmacia
- Rastrear mi uso de productos de Genentech
- Para fines administrativos de Genentech o de nuestros socios

3 AVISOS

Esta autorización y aviso de divulgación tiene vigencia durante 1 año a partir de la fecha en que la firmé.

Una vez que firme este formulario, sé que mi PII podría no estar cubierta por las leyes federales que restringen el uso y la divulgación de mi PII. No existe ninguna garantía de que mi PII no se revele a un tercero. Es posible que este tercero no necesite cumplir con las condiciones de esta autorización y aviso de divulgación.

Sé que puedo negarme a firmar este formulario. Puedo retirar la autorización en cualquier momento y por cualquier razón. Esto no afectará el inicio ni la continuación de mi tratamiento, tampoco afectará la calidad de mi tratamiento, ni tendrá efecto alguno en el tratamiento que me brinda mi proveedor de atención médica. Debo enviar un aviso por escrito a Genentech para retirarla. Puedo enviarlo por fax o por correo postal a la dirección que se muestra en esta página. Este retiro entra en vigencia una vez que Genentech lo recibe. Si no firmo este formulario o si retiro mi autorización, Genentech no podrá ayudarme con el acceso a mi(s) producto(s) de Genentech.

Comprendo que, como paciente o firmante, tengo derecho a obtener una copia de esta autorización y aviso de divulgación firmada durante el año en que tenga validez, y hasta tres años después de que se firme.

4 ACEPTACIÓN DE DISTRIBUCIÓN

Si recibo productos gratuitos de la GATCF, usaré los productos de Genentech como mi proveedor de atención médica me los recetó. No venderé o distribuiré los productos de Genentech. Entiendo que es ilegal hacerlo. Soy responsable de asegurarme de que cualquier producto de Genentech se envíe a una dirección segura cuando me hagan el envío. Sé que es mi deber controlar cualquier producto de Genentech mientras esté en mi poder.

Este aviso por escrito se debe firmar, fechar y enviar por correo postal, fax o en forma electrónica a:

Genentech Access Solutions
1 DNA Way, Mail Stop #858a
South San Francisco, CA 94080-4990

Fax: (800) 963-1792

5 FIRMA Y FECHA (OBLIGATORIAS)

He leído este documento o me lo han explicado. Al firmar este formulario, sé que estoy autorizando la divulgación y entrega de mi PII como se analiza en este formulario de autorización. **Complete toda la información a continuación. Asegúrese de firmar y fechar este formulario. Si no lo hace, se podría retrasar el proceso para brindarle ayuda.**

Debe firmar y colocar la fecha aquí _____ _____ _____
Firma del Paciente o de la Persona Legalmente Autorizada | Relación con el Paciente | Fecha de la Firma

Debe poner aquí su nombre, en letra de imprenta _____ _____
Nombre del Paciente, en Letra de Imprenta | Dirección del Paciente/Contacto Alternativo

Si firma por el paciente, debe poner aquí su nombre, en letra de imprenta _____ _____
Nombre de la Persona Legalmente Autorizada/Nombre del Contacto Alternativo | Teléfono del Contacto

☐ Se puede dejar un mensaje detallado*: Autorizo a Genentech Access Solutions/la GATCF a dejar un mensaje detallado en el siguiente número: _____

*Comprendo que este mensaje puede incluir PII, lo cual comprende, pero no se limita a, el nombre del medicamento que se me recetó, el nombre de mi médico y detalles relativos a la cobertura de seguro

6 INFORMACIÓN FINANCIERA (GATCF ÚNICAMENTE)

INGRESOS FAMILIARES TOTALES CORRESPONDIENTES AL AÑO CALENDARIO PREVIO: $ _____

Lea el testimonio siguiente: Comprendo que para reunir los requisitos a fin de recibir medicamentos gratuitos, la GATCF tiene ciertos criterios que se deben cumplir, lo que incluye los ingresos. Certifico que mi declaración anterior de los ingresos familiares totales correspondientes al año calendario previo es verdadera, y que no cuento con recursos económicos ni cobertura de seguro para pagar los productos de Genentech Sé que la GATCF podría solicitarme una copia de mi formulario 1040 del IRS u otra prueba de mis ingresos para propósitos de auditoría. Estoy de acuerdo con proporcionar en forma oportuna mis documentos financieros, si me los solicitan. Además, notificaré inmediatamente a la GATCF si cambia mi situación de seguro. Tenga en cuenta que la GATCF ejercerá todos los recursos legales apropiados, lo que incluye un juicio de indemnización por daños y perjuicios en litigio, en el caso de que la GATCF determine que esta certificación es falsa o que el testimonio financiero es falso o inexacto. Al firmar este testimonio, certifico que el monto de mis ingresos familiares anuales declarados arriba es verdadero y exacto, a mi leal saber y entender.

Firme y coloque la fecha aquí (Se requiere para la Inscripción en la GATCF) _____ _____
Firma del Paciente o de la Persona Legalmente Autorizada | Fecha de la Firma

7 UN PROGRAMA OPCIONAL Y GRATUITO DE ASISTENCIA AL PACIENTE

Deseo inscribirme en un programa opcional y gratuito de asistencia al paciente brindado por Genentech. Entiendo que se necesita mi PII para que pueda participar en este programa. También sé que se compartirá mi PII con Genentech Access Solutions y con el programa de asistencia al paciente. Puedo elegir que se me contacte por correo, correo electrónico o teléfono. Entiendo que mi PII no será compartida fuera de Genentech, ni por sus agentes. Acepto que Genentech o sus agentes se pongan en contacto conmigo en el futuro sobre este programa.

La política de privacidad de Genentech se puede encontrar en Genentech-Access.com. Entiendo que no tengo que firmar esta parte del formulario. No tiene ningún efecto a la hora de obtener mi medicamento. No forma parte de recibir asistencia de Genentech Access Solutions. También sé que puedo cancelar esta inscripción en el programa de asistencia al paciente en cualquier momento. Para cancelar, puedo llamar al (877) 436-3683.

Forma preferida de ponerse en contacto conmigo (Marque el casillero que corresponda y complete su información. Puede marcar más de un casillero.):

☐ Correo electrónico: _____ ☐ Número de teléfono: _____ ¿Se puede dejar un mensaje? ☐ Sí ☐ No

☐ Dirección: _____

Elija inscribirse firmando aquí _____ _____
Firma del Paciente o de la Persona Legalmente Autorizada (Debe firmar aquí para inscribirse en el programa de asistencia al paciente) | Fecha de la Firma

Pulmozyme®, su logotipo y el logotipo de Access Solutions son marcas comerciales registradas de Genentech, Inc

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STATEMENT OF MEDICAL NECESSITY (SMN)
for Pulmozyme® (dornase alfa) Inhalation Solution

Phone: (800) 690-3023 Fax: (800) 963-1792 PulmozymeAccessSolutions.com

Please complete with a ballpoint pen.

Pulmozyme® dornase alfa INHALATION SOLUTION

Access Solutions®

☐ Benefits Investigation/Prior Authorization ☐ Appeals Support
☐ Co-pay Assistance ☐ GATCF† Patient Assistance ☐ Other _____

PATIENT

Last name* _____ First name* _____ Birth date* _____ Gender* ☐ Male ☐ Female
Street _____ City _____ State* _____ ZIP _____
Home phone (_____) _____ Work/cell phone (_____) _____ Email _____
Alternate contact last name _____ First name _____ Phone (_____) _____
Relationship to patient _____ OK to contact patient? ☐ Yes ☐ No

INSURANCE

☐ **Insurance card attached (optional: see reverse for details)**

☐ HMO/EPO ☐ PPO ☐ POS ☐ Indemnity
☐ Medicare/Medicaid ☐ PBM ☐ Pending Medicaid ☐ No Insurance

Primary insurance (PI) name _____
PI phone _____
PI subscriber name _____
PI subscriber ID # _____
Policy/group # _____
Insurance card attached? ☐ Yes ☐ No

☐ HMO/EPO ☐ PPO ☐ POS ☐ Indemnity
☐ Medicare/Medicaid ☐ PBM ☐ Pending Medicaid ☐ No Insurance

Secondary insurance (SI) name _____
SI phone _____
SI subscriber name _____
SI subscriber ID # _____
Policy/group # _____
Insurance card attached? ☐ Yes ☐ No

DIAGNOSIS

Diagnosis*: ☐ Cystic Fibrosis (277.02) ☐ Other Specify by ICD-9 _____

Forced Expiratory Volume (FEV1): ☐ Mild – greater than 70% ☐ Moderate – between 40% and 70%
☐ Severe – less than 40% ☐ Patient under 6 years old

Prescription Type: ☐ New start ☐ Continuing therapy ☐ Restart therapy
Has patient started treatment? ☐ Yes ☐ No Anticipated date of treatment _____

PRESCRIPTION

Pulmozyme® Regimen 2.5 mL (dornase alfa) Inhalation Solution ☐ Drug allergies _____ ☐ NKDA

DISPENSE: ☐ 30-day supply ☐ 60-day supply ☐ 90-day supply Refill _____ times SIG ☐ QD ☐ BID

Nebulizer (check ONE box only) ☐ Sidestream® Nebulizer (Part #MS2400) ☐ PARI LC® Jet Nebulizer
☐ PARI BABY™ Mask – specify size ☐ size 0 ☐ size 1 ☐ size 2 ☐ size 3
(All masks come with one PARI LC Jet Nebulizer)

PRESCRIBER

Prescriber's last name* _____ First name* _____
Practice name _____ Specialty _____
Street* _____ City* _____ State* _____ ZIP* _____
Phone (_____) _____ Fax (_____) _____
Prescriber Tax ID _____ Prescriber NPI‡ _____
DEA #* _____ Group NPI _____ State license # _____ PTAN§ _____
Reimbursement/clinical contact last name _____ First name _____
Reimbursement/clinical contact phone (_____) _____ Fax (_____) _____

UNAPPROVED USE WARNING Please read the FDA-approved label for Pulmozyme before prescribing. If the indication for which you are prescribing Pulmozyme is not listed in the label, you are prescribing Pulmozyme for an "unapproved" use. The fact that the use for which you are prescribing Pulmozyme is not listed in the FDA-approved label indicates that the FDA has not approved the efficacy, dosage amount or safety of Pulmozyme when used for such a use. Nevertheless, GATCF will consider providing Pulmozyme for your patient with this admonition, based upon your medical order, within program requirements.

- By signing below I certify that (a) the above therapy is medically necessary, (b) I have received the necessary authorization to release the above referenced information and other protected health information (as defined in the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc., Pulmozyme Access Solutions and contracted dispensing pharmacy or other contractors for the purpose of seeking reimbursement, assisting in initiating or continuing therapy and/or the evaluation of the patient's eligibility for GATCF, as a break in treatment would negatively impact the patient's therapeutic outcome, (c) I will not sell or bill for any free product received in my office for patients from GATCF or Starter Programs and (d) I appoint Pulmozyme Access Solutions solely to convey on my behalf to the pharmacy chosen by the above-named patient the prescription described herein.
- I agree to comply with the program guidelines as established by Genentech, Inc. and understand that GATCF, at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of the information submitted.

Prescriber's Signature* _____ Date* _____
(Original signature required.)

*Required field †Genentech® Access to Care Foundation ‡National Provider Identifier §Prescriber Transaction Access Number

STATEMENT OF MEDICAL NECESSITY (SMN)

PLEASE WRITE LEGIBLY AND COMPLETE ALL REQUIRED FIELDS (*) TO PREVENT DELAY.

SERVICES REQUESTED

- Check the appropriate services requested Pulmozyme Access Solutions and/or GATCF cannot perform services without your specific authorization

INSURANCE

- If the patient is insured, provide a front and back copy of the patient's insurance card

DIAGNOSIS

- Check the appropriate Diagnosis Code
- If "Other" is checked, specify the ICD-9 code
- Check the appropriate box to indicate FEV1 level If the patient is under 6 years old, check the appropriate box
- Check the appropriate box to indicate whether the prescription is for new, continuing or restart of therapy
- Check the appropriate box to indicate whether the patient has started treatment
- Include the anticipated treatment start date, if applicable

PRESCRIPTION

- Please ensure that you complete all areas of the prescription portion clearly and completely
- Patients who are receiving free medication through GATCF will need to make separate arrangements to obtain a nebulizer
- A prescription cannot be processed with a stamped signature The prescriber must sign and date the form to make the prescription valid
- Pulmozyme® (dornase alfa) Inhalation Solution can be dosed monthly using 2 5 mL (dornase alfa inhalation solution) and administered either once (QD) or twice (BID) daily
- Pulmozyme must be stored in the refrigerator at 2°C-8°C (36°F-46°F) and protected from strong light It should be kept refrigerated during transport and should not be exposed to room temperatures for a total time of 24 hours The solution should be discarded if cloudy or discolored Pulmozyme contains no preservative and, once opened, the entire contents of the ampule must be used or discarded Patients should be instructed in the proper use and maintenance of the nebulizer and compressor system used in delivery

PRESCRIBER

- This form cannot be processed without an original signature

ATTACH TO COMPLETED SMN

- **Attach a signed and dated Patient Authorization and Notice of Release of Information (PAN) form.** Pulmozyme Access Solutions cannot work with the insurance plan on your patient's behalf without a signed and dated PAN form

REMINDER: This form cannot be processed without a prescriber's signature and date, as well as a signed and dated PAN form

PulmozymeAccessSolutions.com
Phone: (800) 690-3023 Fax: (800) 963-1792

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Sidestream® is a registered trademark of Medic-Aid Limited Corporation
PARI LC® is a registered trademark of PARI GmbH Spezialisten fuer effektive Inhalation Corporation

Pulmozyme® dornase alfa INHALATION SOLUTION

Access Solutions®

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PUL0000654701 10/11

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PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION (PAN)

Genentech
A Member of the Roche Group | Access Solutions®

Phone: (866) 681-3261 **Fax:** (866) 681-3288 **Genentech-Access.com/Rheumatology**

ACS/092914/0049 10/14

Genentech Rheumatology Access Solutions is a free program for you from Genentech.

We work to help you pay for your Genentech product. We can help in many different ways. We assist people who have a health care plan as well as those who don't.

If you don't have a health care plan, or your plan won't pay for your Genentech product(s), we might be able to help. If you meet certain financial and medical standards, we can supply free medicine. This is done through the Genentech® Access to Care Foundation (GATCF).

For us to help, we need to look at, use and disclose your personally identifiable information (PII). Your health care provider and health care plan can disclose your PII to us only with your written authorization. By signing this authorization form, you are authorizing your health care provider and health care plan to release your PII to us, and authorizing us to disclose your PII as necessary to perform services for you. Once you sign this form and it is sent back to us, or submitted electronically by you or by your health care provider on your behalf, we can start to provide these services. You can choose not to agree to this authorization, however, please note that we cannot provide our services without it. This means you might need to pay for certain medications on your own.

PLEASE READ THROUGH THIS FORM CAREFULLY. IF YOU HAVE ANY QUESTIONS, TALK TO YOUR HEALTH CARE PROVIDER'S OFFICE OR CALL US AT THE PHONE NUMBER LISTED AT THE TOP OF THIS PAGE.

1 INFORMATION TO BE DISCLOSED OR USED

This signed form lets my health care providers and health care plans send my PII, and this form electronically, to Genentech Access Solutions and/or GATCF. This includes:

- All my health records relating to my treatment
- Information about my health care plan benefits
- The dollar balance left on the total of the lifetime payments covered by my health care plan policy (if this applies to my plan)
- Any information having a bearing on my health or my adherence to my treatment

All of the above is considered part of my PII. I know this could include information about:

- Sexually transmitted diseases
- Mental health conditions
- Genetic test results

2 WHO MAY SEE AND USE MY PII

My PII may be seen by Genentech Access Solutions and/or GATCF. These are programs sponsored by Genentech. Its address is 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. It may also be seen by anyone helping Genentech Access Solutions perform services, including Genentech employees and any of Genentech's partners, for the purpose of facilitating access to Genentech products. Genentech may share your PII with Sponsors, and/or their agents and affiliates, and your health care provider and health plan.

My PII may be used only in these ways:

- Helping with my health care plan coverage for Genentech products
- Applying to GATCF
- Determining eligibility for alternative forms of coverage and sources of funding
- Coordination of prescription fulfillment through a pharmacy
- Tracking my use of Genentech products
- For Genentech, or our partners' administrative purposes

3 NOTICES

This authorization and notice of release is in effect for 1 year from the date I signed it.

Once I sign this form, I know my PII might not be covered by any federal law that restricts the use and disclosure of my PII. There is no guarantee my PII might not be released to a third party. This third party might not need to follow the conditions of this authorization and notice of release.

I know I can refuse to sign this form. I may withdraw authorization at any time and for any reason. This won't affect the start or continuing of my treatment, the quality of my treatment, and will have no impact on my treatment by my health care provider. To withdraw it, I must send a written notice to Genentech. It can be sent by fax or by mail to the address on this page. This withdrawal goes into effect once it is received by Genentech. If I don't sign this form or if I withdraw my authorization, Genentech will not be able to help me with access to my Genentech product(s).

I understand that I, as the patient or signer, have a right to obtain a copy of this signed authorization and notice of release during the one year it is valid, and up to three years after it is signed.

4 DISTRIBUTION ACCEPTANCE

If I receive free product from GATCF, I will use Genentech products as my health care provider has prescribed them to me. I will not sell or distribute Genentech products. I understand it is unlawful to do this. I am responsible for ensuring any Genentech product is sent to a secure address when it is shipped to me. I know it is my duty to control any Genentech product while it stays in my possession.

This written notice must be signed, dated, and mailed, faxed, or electronically submitted to

Genentech Access Solutions
1 DNA Way, Mail Stop #858a
South San Francisco, CA 94080-4990

Fax: (866) 681-3288

5 SIGNATURE AND DATE (REQUIRED)

I have read this document or have had it explained to me. By signing this form, I know I am authorizing the release and disclosure of my PII as discussed in this authorization form. **Please fill in all information below. Be sure to sign and date this form. If you don't, it could hold up the process for helping you.**

You must sign and date here

_____ _____ _____
Signature of Patient or Legally Authorized Person | Relationship to Patient | Date Signed

You must print your name here

_____ _____
Print Patient's Name | Patient/Alternate Contact Address

If signing for the patient you must print your name here

_____ _____
Legally Authorized Person/Alternate Contact Name | Contact Phone

☐ OK to leave a detailed message*: I authorize Genentech Access Solutions/GATCF to leave a detailed message at the following number: _____

*I understand this message may include PII, including but not limited to, the name of the medication I have been prescribed, my doctor's name, and details regarding insurance coverage

6 FINANCIAL INFORMATION (GATCF ONLY)

TOTAL HOUSEHOLD INCOME FOR THE PREVIOUS CALENDAR YEAR: $ _____

Read the following attestation: I understand that to qualify for free medicine, GATCF has criteria that must be met, including income. I certify the above statement of my total annual household income for the previous calendar year is true, and I do not have the financial resources or insurance coverage to pay for Genentech products. I know that GATCF could ask me for a copy of my IRS 1040 form or other proof of income for the purpose of an audit. I agree to provide my financial documentation in a timely manner, if so requested. In addition, I will notify GATCF immediately if my insurance situation changes. Please note that GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the financial attestation is false or inaccurate. By signing this attestation, I certify that the above statement of my annual household income amount is true and accurate, to the best of my knowledge.

Sign and date here (Required for GATCF Enrollment)

_____ _____
Signature of Patient or Legally Authorized Person | Date Signed

7 AN OPTIONAL AND FREE PATIENT SUPPORT PROGRAM

I want to enroll in an optional and free patient support program from Genentech. I understand my PII is needed for me to be a part of this program. I also know my PII will be shared with Genentech Access Solutions and the patient support program. I may choose to be contacted by mail, email or phone. I understand my PII won't be shared outside of Genentech, or by its agents. I agree to let Genentech or its agents contact me in the future about this program.

The Genentech privacy policy can be found at Genentech-Access.com. I understand I do not have to sign this part of the form. It plays no role in getting my medicine. It is not part of receiving help from Genentech Access Solutions. I also know I may cancel this enrollment in the patient support program at any time. To cancel, I can call (877) 436-3683.

Preferred way to contact me (Please check the box that applies and fill in your information. You can check more than one box.):
☐ Email: _____ ☐ Phone Number: _____ Okay to leave a message? ☐ Yes ☐ No
☐ Address: _____

Choose to enroll by signing here

_____ _____
Signature of Patient/Legally Authorized Person (You must sign here to enroll in the patient support program) | Date Signed

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Genentech
A Member of the Roche Group

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AUTORIZACIÓN DEL PACIENTE Y AVISO DE DIVULGACIÓN DE INFORMACIÓN (PAN)

Genentech
A Member of the Roche Group | Access Solutions®

Teléfono: (866) 681-3261 **Fax:** (866) 681-3288 **Genentech-Access.com/Rheumatology**

ACS/091814/0031(1) 10/14

Genentech Rheumatology Access Solutions es un programa gratuito de Genentech para usted.

Trabajamos para ayudarlo a pagar su producto de Genentech. Podemos ayudarlo de muchas maneras diferentes. Ayudamos a las personas que cuentan con un plan de salud y a quienes no lo tienen.

Si no tiene plan de salud, o si su plan no pagará por su(s) producto(s) de Genentech, es posible que podamos ayudarlo. Si cumple con ciertos estándares financieros y médicos, podemos proporcionarle el medicamento en forma gratuita. Esto se hace a través de la Genentech® Access to Care Foundation (GATCF).

Para ayudarlo, necesitamos ver, usar y revelar su información personal identificable (personally identifiable information, PII). Su proveedor de atención médica y su plan de salud pueden revelarnos su PII únicamente con su autorización por escrito. Al firmar este formulario de autorización, usted autoriza a su proveedor de atención médica y a su plan de salud a entregarnos su PII, y nos autoriza a revelar su PII según sea necesario para proporcionarle servicios. Una vez que firme este formulario y este se nos envíe de regreso, o usted o su proveedor de atención médica en su nombre nos lo envíen electrónicamente, podemos empezar a proporcionarle estos servicios. Usted puede optar por no acceder a esta autorización, sin embargo, tenga en cuenta que no podemos proporcionarle nuestros servicios sin ella. Esto significa que podría ser necesario que pague ciertos medicamentos por su propia cuenta.

LEA CUIDADOSAMENTE ESTE FORMULARIO. SI TIENE PREGUNTAS, HABLE CON EL CONSULTORIO DE SU PROVEEDOR DE ATENCIÓN MÉDICA O LLÁMENOS AL NÚMERO TELEFÓNICO QUE APARECE EN LA PARTE SUPERIOR DE ESTA PÁGINA.

1 INFORMACIÓN QUE SE REVELARÁ O USARÁ

Este formulario firmado les permite a mis proveedores de atención médica y planes de salud enviar mi PII, y este formulario en forma electrónica, a Genentech Access Solutions y/o a la GATCF. Esto incluye:

- Todos mis registros médicos relacionados con mi tratamiento
- Información sobre los beneficios de mi plan de salud
- El saldo en dólares que queda del total de los pagos de por vida que cubre la póliza de mi plan de salud (si esto se aplica a mi plan)
- Toda información relacionada con mi salud o el cumplimiento de mi tratamiento

Todo lo mencionado arriba se considera parte de mi PII. Sé que esto podría incluir información sobre:

- Enfermedades de transmisión sexual
- Afecciones de salud mental
- Resultados de pruebas genéticas

2 QUIÉN PUEDE VER Y USAR MI PII

Mi PII puede ser vista por Genentech Access Solutions y/o la GATCF. Estos son programas que patrocina Genentech. Su dirección es 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. También puede ser vista por cualquier persona que ayude a Genentech Access Solutions en la prestación de servicios, lo que incluye a empleados de Genentech y a cualquier socio de Genentech, a los efectos de facilitar el acceso a los productos de Genentech. Genentech puede compartir su PII con los Patrocinadores, y/o sus agentes y afiliadas, y con su proveedor de atención médica y plan de salud.

Mi PII se puede usar solamente de las maneras siguientes:

- Ayudarme con la cobertura de mi plan de salud para productos de Genentech
- Presentar una solicitud a la GATCF
- Determinar la elegibilidad para formas de cobertura y fuentes de financiamiento alternativas
- Coordinación del surtido de recetas a través de una farmacia
- Rastrear mi uso de productos de Genentech
- Para fines administrativos de Genentech o de nuestros socios

3 AVISOS

Esta autorización y aviso de divulgación tiene vigencia durante 1 año a partir de la fecha en que la firmé.

Una vez que firme este formulario, sé que mi PII podría no estar cubierta por las leyes federales que restringen el uso y la divulgación de mi PII. No existe ninguna garantía de que mi PII no se revele a un tercero. Es posible que este tercero no necesite cumplir con las condiciones de esta autorización y aviso de divulgación.

Sé que puedo negarme a firmar este formulario. Puedo retirar la autorización en cualquier momento y por cualquier razón. Esto no afectará el inicio ni la continuación de mi tratamiento, tampoco afectará la calidad de mi tratamiento, ni tendrá efecto alguno en el tratamiento que me brinda mi proveedor de atención médica. Debo enviar un aviso por escrito a Genentech para retirarla. Puedo enviarlo por fax o por correo postal a la dirección que se muestra en esta página. Este retiro entra en vigencia una vez que Genentech lo recibe. Si no firmo este formulario o si retiro mi autorización, Genentech no podrá ayudarme con el acceso a mi(s) producto(s) de Genentech.

Comprendo que, como paciente o firmante, tengo derecho a obtener una copia de esta autorización y aviso de divulgación firmada durante el año en que tenga validez, y hasta tres años después de que se firme.

4 ACEPTACIÓN DE DISTRIBUCIÓN

Si recibo productos gratuitos de la GATCF, usaré los productos de Genentech como mi proveedor de atención médica me los recetó. No venderé o distribuiré los productos de Genentech. Entiendo que es ilegal hacerlo. Soy responsable de asegurarme de que cualquier producto de Genentech se envíe a una dirección segura cuando me hagan el envío. Sé que es mi deber controlar cualquier producto de Genentech mientras esté en mi poder.

Este aviso por escrito se debe firmar, fechar y enviar por correo postal, fax o en forma electrónica a:

Genentech Access Solutions
1 DNA Way, Mail Stop #858a
South San Francisco, CA 94080-4990

Fax: (866) 681-3288

5 FIRMA Y FECHA (OBLIGATORIAS)

He leído este documento o me lo han explicado. Al firmar este formulario, sé que estoy autorizando la divulgación y entrega de mi PII como se analiza en este formulario de autorización. **Complete toda la información a continuación. Asegúrese de firmar y fechar este formulario. Si no lo hace, se podría retrasar el proceso para brindarle ayuda.**

Debe firmar y colocar la fecha aquí _____ _____ _____
Firma del Paciente o de la Persona Legalmente Autorizada | Relación con el Paciente. | Fecha de la Firma

Debe poner aquí su nombre, en letra de imprenta _____ _____
Nombre del Paciente, en Letra de Imprenta | Dirección del Paciente/Contacto Alternativo

Si firma por el paciente, debe poner aquí su nombre, en letra de imprenta _____ _____
Nombre de la Persona Legalmente Autorizada/Nombre del Contacto Alternativo | Teléfono del Contacto

☐ Se puede dejar un mensaje detallado*: Autorizo a Genentech Access Solutions/la GATCF a dejar un mensaje detallado en el siguiente número: _____

*Comprendo que este mensaje puede incluir PII, lo cual comprende, pero no se limita a, el nombre del medicamento que se me recetó, el nombre de mi médico y detalles relativos a la cobertura de seguro

6 INFORMACIÓN FINANCIERA (GATCF ÚNICAMENTE)

INGRESOS FAMILIARES TOTALES CORRESPONDIENTES AL AÑO CALENDARIO PREVIO: $ _____

Lea el testimonio siguiente: Comprendo que para reunir los requisitos a fin de recibir medicamentos gratuitos, la GATCF tiene ciertos criterios que se deben cumplir, lo que incluye los ingresos. Certifico que mi declaración anterior de los ingresos familiares totales correspondientes al año calendario previo es verdadera, y que no cuento con recursos económicos ni cobertura de seguro para pagar los productos de Genentech. Sé que la GATCF podría solicitarme una copia de mi formulario 1040 del IRS u otra prueba de mis ingresos para propósitos de auditoría. Estoy de acuerdo con proporcionar en forma oportuna mis documentos financieros, si me los solicitan. Además, notificaré inmediatamente a la GATCF si cambia mi situación de seguro. Tenga en cuenta que la GATCF ejercerá todos los recursos legales apropiados, lo que incluye un juicio de indemnización por daños y perjuicios en litigio, en el caso de que la GATCF determine que esta certificación es falsa o que el testimonio financiero es falso o inexacto. Al firmar este testimonio, certifico que el monto de mis ingresos familiares anuales declarados arriba es verdadero y exacto, a mi leal saber y entender.

Firme y coloque la fecha aquí (Se requiere para la Inscripción en la GATCF) _____ _____
Firma del Paciente o de la Persona Legalmente Autorizada | Fecha de la Firma

7 UN PROGRAMA OPCIONAL Y GRATUITO DE ASISTENCIA AL PACIENTE

Deseo inscribirme en un programa opcional y gratuito de asistencia al paciente brindado por Genentech. Entiendo que se necesita mi PII para que pueda participar en este programa. También sé que se compartirá mi PII con Genentech Access Solutions y con el programa de asistencia al paciente. Puedo elegir que se me contacte por correo, correo electrónico o teléfono Entiendo que mi PII no será compartida fuera de Genentech, ni por sus agentes. Acepto que Genentech o sus agentes se pongan en contacto conmigo en el futuro sobre este programa.

La política de privacidad de Genentech se puede encontrar en Genentech-Access.com. Entiendo que no tengo que firmar esta parte del formulario. No tiene ningún efecto a la hora de obtener mi medicamento. No forma parte de recibir asistencia de Genentech Access Solutions. También sé que puedo cancelar esta inscripción en el programa de asistencia al paciente en cualquier momento. Para cancelar, puedo llamar al (877) 436-3683.

Forma preferida de ponerse en contacto conmigo (Marque el casillero que corresponda y complete su información. Puede marcar más de un casillero.):

☐ Correo electrónico: _____ ☐ Número de teléfono: _____ ¿Se puede dejar un mensaje? ☐ Sí ☐ No

☐ Dirección: _____

Elija inscribirse firmando aquí _____ _____
Firma del Paciente o de la Persona Legalmente Autorizada (Debe firmar aquí para inscribirse en el programa de asistencia al paciente) | Fecha de la Firma

El logotipo de Access Solutions es una marca comercial registrada de Genentech, Inc

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A Member of the Roche Group

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STATEMENT OF MEDICAL NECESSITY (SMN)

Please write legibly and complete all required fields (*) to prevent delays

Phone: (866) 681-3261 Fax: (866) 681-3288 Genentech-Access.com/Rheumatology

Access Solutions®

SERVICES REQUESTED* (check only those that apply)

☐ Benefits Investigation/ Prior Authorization ☐ Appeals Support ☐ Co-pay Assistance ☐ GATCF† Eligibility Screening ☐ GATCF Patient Assistance

PATIENT INFORMATION

Last name* _____

First name* _____

Birth date* _____ Gender* ☐ Male ☐ Female

Street _____

City _____ State* _____ ZIP _____

Home phone _____

Work/cell phone _____ Email _____

Alternate contact _____

Relationship to patient _____

OK to contact patient for additional information? ☐ Yes ☐ No

INSURANCE INFORMATION

Does the patient have insurance? ☐ Yes ☐ No

Primary insurance name: _____

Phone _____

Subscriber name _____

Subscriber ID # _____

Policy/group # _____

Secondary insurance name: _____

Phone _____

Subscriber name _____

Subscriber ID # _____

Policy/group # _____

DIAGNOSIS/TREATMENT

DIAGNOSIS (highest level of specificity)*:

☐ Rheumatoid Arthritis (RA) (714 0)

☐ Granulomatosis with Polyangiitis (GPA) (446 4)

☐ Microscopic Polyangiitis (MPA) (446 0)

☐ Systemic Juvenile Idiopathic Arthritis (SJIA) - ICD-9-CM _____

☐ Polyarticular Juvenile Idiopathic Arthritis (PJIA) - ICD-9-CM _____

☐ Other Specify by ICD-9-CM _____

Check one desired patient therapy*:

☐ Rituxan® (rituximab)

☐ ACTEMRA® (tocilizumab) IV infusion

☐ ACTEMRA SC self-injectable

Select one ☐ DMARD-IR ☐ TNF-IR

Previous treatment(s) since diagnosis:

☐ Cimzia ☐ Enbrel ☐ Humira ☐ Methotrexate ☐ Orencia

☐ Remicade ☐ Simponi ☐ Xeljanz ☐ Other _____

Has patient started prescribed therapy? ☐ Yes ☐ No

Next date of treatment _____

Concurrent therapy prescribed with Rituxan or ACTEMRA _____

INFUSION AND DRUG ACQUISITION INFORMATION

Specialty pharmacy needed for Rituxan or ACTEMRA dispensing?

☐ Yes ☐ No (MD's office will supply)

Preferred specialty pharmacy _____

Place of infusion:

☐ Prescribing physician's office ☐ Other physician's office

☐ Hospital outpatient ☐ Other _____

Infusion site name _____

Infusion site tax ID # _____ Infusion site NPI‡ # _____

Street _____

City _____ State _____ ZIP _____

Contact name _____

Phone _____

PRESCRIBER INFORMATION

Last name* _____

First name* _____

Practice name _____

Specialty _____

Street _____

City _____ State* _____ ZIP _____

Phone _____ Fax _____

Prescriber tax ID # _____ Prescriber NPI # _____

DEA #* _____ Group NPI # _____

State license # _____ PTAN§ _____

Reimbursement/clinical contact name _____

Reimbursement/clinical contact phone/fax _____

SHIPPING FOR GATCF

Shipping location ☐ Patient ☐ Practice ☐ Facility

Shipping address same as address listed in Patient or Prescriber sections of this form? ☐ Yes ☐ No If no, complete the remainder of this section

Facility/practice or patient name _____

DEA # _____ License # _____

Street (street address required, no PO boxes) _____

City _____ State _____ ZIP _____

Contact name _____

Phone _____ Fax _____

*Required field

†Genentech® Access to Care Foundation

‡National Provider Identifier

§Provider Transaction Access Number

PRESCRIPTION

For Rituxan® (rituximab) Patients Only

SIG: Infuse _____ mg on ☐ Day 1 and Day 15 ☐ Other _____
☐ Once a week for 4 weeks Refill _____ times

☐ Dispense Rituxan vials _____ 100-mg/dose _____ 500-mg/dose

For ACTEMRA® (tocilizumab) Patients Only

Intravenous (IV) Infusion

SIG: Infuse _____ mg ☐ Once every 4 weeks ☐ Other _____
☐ Once every 2 weeks Refill _____ times

☐ Dispense ACTEMRA vials
_____ 80-mg/dose _____ 200-mg/dose _____ 400-mg/dose

Subcutaneous self-injectable

Inject 162 mg

☐ Once a week ☐ Once every 2 weeks ☐ Other _____
Dispense ☐ 1 month ☐ 2 month ☐ 3 month ☐ Other _____
Patient weight _____
Refill _____ times

ACT Fast free starter supply only (ACTEMRA subcutaneous patients only)

Drug: ACTEMRA subcutaneous self-injectable 162 mg
Dispense 15-day supply ☐ Once every week ☐ Once every 2 weeks
Patient weight _____
Refill _____ times

UNAPPROVED USE WARNING: Please read the FDA-approved labels for Rituxan and ACTEMRA before prescribing. If the indication for which you are prescribing Rituxan or ACTEMRA is not listed in the label, you are prescribing Rituxan or ACTEMRA for an "unapproved" use. The fact that the use for which you are prescribing Rituxan or ACTEMRA is not listed in the FDA-approved label indicates that the FDA has not approved the efficacy, dosage amount or safety of Rituxan or ACTEMRA when used for such a use. Nevertheless, GATCF will consider providing Rituxan or ACTEMRA for your patient with this admonition, based upon your medical order, within program requirements.

By signing below, I certify that (a) the above therapy is medically necessary, (b) I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc., Genentech Access Solutions and contracted dispensing pharmacy or other contractors for the purpose of seeking reimbursement, assisting in initiating or continuing therapy and/or the evaluation of the patient's eligibility for GATCF related to Genentech products, as a break in treatment would negatively impact the patient's therapeutic outcome, (c) I will not attempt to seek reimbursement for free or replacement product provided directly to the patient or for the dates of service for which free or replacement product was provided and (d) I appoint Genentech Access Solutions solely to convey on my behalf to the pharmacy chosen by the above-named patient the prescription described herein.

I agree to comply with the program guidelines as established by Genentech, Inc. and understand that GATCF, at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of the information submitted. I further understand that Genentech will provide vial replacement in a configuration that will create the least amount of wastage.

Print patient's name here

Patient last name* _____ First name*. _____ Birth date*. _____

Sign and date here

Prescriber's Signature* _____ Date* _____
(Original or stamped signature required)

Complete this form online via My Patient Solutions™, our online patient management tool. Visit Genentech-Access.com/Rheumatology to register for My Patient Solutions.

*Required field

STATEMENT OF MEDICAL NECESSITY (SMN)

Please write legibly and complete all required fields (*) to prevent delays

SERVICES REQUESTED

- Check the appropriate services requested Genentech Access Solutions and/or GATCF cannot perform services without your specific authorization

INSURANCE INFORMATION

- If the patient is insured, provide a front and back copy of the patient's drug card

DIAGNOSIS/TREATMENT

- Check the appropriate Diagnosis Code
- If "Other" is checked, specify the ICD-9-CM code to the highest level of specificity
- By checking the appropriate box, indicate the previous treatment
- If "Other" is checked, identify the treatment(s)

INFUSION AND DRUG ACQUISITION INFORMATION

- Check the appropriate box to indicate the need for a specialty pharmacy to dispense Rituxan® (rituximab) or ACTEMRA® (tocilizumab) Genentech Access Solutions will verify with your patient's insurance plan whether a specialty pharmacy is in network
- Complete according to the planned (patient has not yet received Rituxan or ACTEMRA) or administered (patient has already been infused with Rituxan or ACTEMRA) dosing

PRESCRIPTION

Please indicate the prescribed therapy (Rituxan or ACTEMRA)

- Complete the dose and refill fields only if you are planning to use a specialty pharmacy to acquire Rituxan or ACTEMRA for your patient, or if you are requesting GATCF assistance for your patient
- If you will not infuse the patient in your office and need assistance with locating an infusion site, Genentech Access Solutions will verify with your patient's insurance plan the infusion sites that are in network

PRESCRIBER INFORMATION

- This form cannot be processed without an original or stamped signature

ATTACH TO COMPLETED SMN

- Attach a signed and dated Patient Authorization and Notice of Release of Information (PAN) form Genentech Access Solutions and/or GATCF cannot work with the insurance plan on your patient's behalf without a signed and dated PAN form
- Providing additional documents or information with this form, other than what is requested, will delay processing

REMINDER: This form cannot be processed without a prescriber's signature and date, as well as a signed and dated PAN form

Genentech-Access.com
Phone: (866) 681-3261 Fax: (866) 681-3288

Rituxan® is a registered trademark of Biogen Idec, Inc
ACTEMRA® is a registered trademark of Chugai Seiyaku Kabushiki Kaisha Corp , a member of the Roche Group
The Access Solutions logo is a registered trademark of Genentech, Inc

Access Solutions®

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Genentech® Access to Care Foundation (GATCF)
Confirmation of Infusion or Injection

Phone (866) 681-3329 - Fax (866) 681-3338

This completed document is required to participate in the Genentech Access to Care Foundation (GATCF) free Rituxan® (rituximab) program. This form is available online via My Patient Solutions™ for applicable brands*. Link to My Patient Solutions directly from Genentech-Access.com/Rituxan to enroll and manage your patients online.

Instructions: *All fields required.* Complete this form after each infusion/injection and fax completed form to GATCF at the number listed above or submit through My Patient Solutions.

Date of Service:	Amount Infused/Injected:	Date of Service:	Amount Infused/Injected:
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg

Please complete, sign and date the following statement. (REQUIRED)

Print Patient Name (Required): _____

Patient's Date of Birth (Required): _____

Authorized HCP Signature (Required)†: _____

Date of Signature (Required): _____

Next Scheduled Infusion (if applicable): _____

CERTIFICATION: By signing above, I certify that all information on this form is correct, and this patient has been infused/injected with product listed above. I know that GATCF could ask me for a copy of the patient's infusion/injection records for the purpose of an audit. I agree to provide a copy of the patient's infusion/injection records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the Confirmation of Infusion or Injection is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*Only BioOncology products, Rheumatology products and XOLAIR are supported by My Patient Solutions.
†The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP)

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A Member of the Roche Group

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Genentech® Access to Care Foundation (GATCF)
Insurance Attestation – HCP Administered Drugs

Phone (866) 681-3329 - Fax (866) 681-3338

This form is required for each of your patient's insurances and will serve as proof that the patient's insurance company will not cover the prescribed Rituxan® (rituximab) therapy. This form should be completed once you have the outcome of the first level of appeal.

Check ALL box(es) that apply to your patient and fax to GATCF at the number listed above.

- ☐ My office received a first-level appeal denial and the initial claim or Prior Authorization (PA) denial is upheld.
  - Date of initial claim or PA denial: ____/____/____
  - Reason for initial claim or PA denial:_____
  - Date of first-level appeal denial: ____/____/____
  - Reason for first-level appeal denial:_____
- ☐ My office received a recoupment for date of service:____/____/____
  - Date of recoupment letter:____/____/____
  - Reason for recoupment:_____
- ☐ My office received a peer-to-peer denial.
  - Date of review:____/____/____
  - Reason denial:_____
- ☐ My patient has met the daily/yearly CAP for insurance coverage.
  - Date CAP was met:____/____/____
  - Date CAP reset:____/____/____

PLEASE NOTE: *If the patient's insurance denied coverage due to an administrative error, untimely filing or not following the insurance policy requirements, your patient does not meet GATCF insurance criteria. GATCF requires one level of appeal for patients to be considered rendered uninsured.*

Please complete, sign and date the following statement. (REQUIRED)

Authorized HCP Signature (Required): _____ Date:_____

Print Physician First and Last Name: _____

Patient Insurance Company Name: _____

Print Patient's First and Last Name: _____

Patient's Date of Birth: _____

CERTIFICATION: By signing above, I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements.

I know GATCF could ask me for a copy of the patient's insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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Genentech® Access to Care Foundation (GATCF)
Insurance Attestation – Patient-Administered Drugs

Phone (800) 530-3083 - Fax (877) 428-2326

This form is required for each of your patient's insurances and will serve as proof that the patient's insurance company will not cover the prescribed Tarceva® (erlotinib) therapy. Complete this form when the outcome for any situations listed below has been met.

Check ALL box(es) that apply to your patient and fax to GATCF at the number listed above.

- ☐ My office received an initial claim denial or Prior Authorization (PA) denial.
  Date of initial claim denial or PA denial: _____/_____/_____
  Reason for denial:_____
- ☐ My office has submitted for a first-level appeal.
  Date appeal letter submitted:_____/_____/_____
- ☐ My office received a first-level appeal denial.
  Date of appeal denial letter:_____/_____/_____
  Reason for denial:_____
- ☐ My office received a peer-to-peer denial.
  Date of review:_____/_____/_____
  Reason for denial:_____
- ☐ My patient has met the daily/yearly CAP for insurance coverage.
  Date CAP was met:_____/_____/_____
  Date CAP reset:_____/_____/_____

PLEASE NOTE: If the patient's insurance denied coverage due to an administrative error, untimely filing or not following the insurance policy requirements, your patient does not meet GATCF insurance criteria. GATCF requires one level of appeal for patients to be considered rendered uninsured.

Please complete, sign and date the following statement. (REQUIRED)

Authorized HCP Signature (Required)*: _____Date:_____
Print Physician First and Last Name: _____
Patient Insurance Company Name: _____
Print Patient's First and Last Name: _____
Patient's Date of Birth: _____

CERTIFICATION: By signing above, I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements.

I know GATCF could ask me for a copy of the patient's insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP)

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Genentech® Access to Care Foundation (GATCF)
Confirmation of Infusion or Injection

Phone (800) 530-3083 - Fax (650) 225-1366

This completed document is required to participate in the Genentech Access to Care Foundation (GATCF) free TNKase® (tenecteplase) program. This form is available online via My Patient Solutions™ for applicable brands*. Link to My Patient Solutions directly from Genentech-Access.com to enroll and manage your patients online.

Instructions: *All fields required.* Complete this form after each infusion/injection and fax completed form to GATCF at the number listed above or submit through My Patient Solutions.

Date of Service:	Amount Infused/Injected:	Date of Service:	Amount Infused/Injected:
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg

Please complete, sign and date the following statement. (REQUIRED)

Print Patient Name (Required): _____

Patient's Date of Birth (Required): _____

Authorized HCP Signature (Required)†: _____

Date of Signature (Required): _____

Next Scheduled Infusion (if applicable): _____

CERTIFICATION: By signing above, I certify that all information on this form is correct, and this patient has been infused/injected with product listed above. I know that GATCF could ask me for a copy of the patient's infusion/injection records for the purpose of an audit. I agree to provide a copy of the patient's infusion/injection records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the Confirmation of Infusion or Injection is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*Only BioOncology products, Rheumatology products and XOLAIR are supported by My Patient Solutions.

†The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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Genentech® Access to Care Foundation (GATCF)
Insurance Attestation – Patient-Administered Drugs

Phone (800) 530-3083 - Fax (877) 428-2326

This form is required for each of your patient's insurances and will serve as proof that the patient's insurance company will not cover the prescribed XELODA® (capecitabine) therapy. Complete this form when the outcome for any situations listed below has been met.

Check ALL box(es) that apply to your patient and fax to GATCF at the number listed above.

- ❑ My office received an initial claim denial or Prior Authorization (PA) denial.
  - Date of initial claim denial or PA denial: _____/_____/_____
  - Reason for denial: _____
- ❑ My office has submitted for a first-level appeal.
  - Date appeal letter submitted: _____/_____/_____
- ❑ My office received a first-level appeal denial.
  - Date of appeal denial letter: _____/_____/_____
  - Reason for denial: _____
- ❑ My office received a peer-to-peer denial.
  - Date of review: _____/_____/_____
  - Reason for denial: _____
- ❑ My patient has met the daily/yearly CAP for insurance coverage.
  - Date CAP was met: _____/_____/_____
  - Date CAP reset: _____/_____/_____

PLEASE NOTE: *If the patient's insurance denied coverage due to an administrative error, untimely filing or not following the insurance policy requirements, your patient does not meet GATCF insurance criteria. GATCF requires one level of appeal for patients to be considered rendered uninsured.*

Please complete, sign and date the following statement. (REQUIRED)

Authorized HCP Signature (Required)*: _____ Date: _____

Print Physician First and Last Name: _____

Patient Insurance Company Name: _____

Print Patient's First and Last Name: _____

Patient's Date of Birth: _____

CERTIFICATION: By signing above, I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements.

I know GATCF could ask me for a copy of the patient's insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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Genentech® Access to Care Foundation (GATCF)
Confirmation of Infusion or Injection

Phone (800) 704-6614 - Fax (800) 704-6615

This completed document is required to participate in the Genentech Access to Care Foundation (GATCF) free XOLAIR®(omalizumab) for subcutaneous program. This form is available online via My Patient Solutions™ for applicable brands*. Link to My Patient Solutions directly from Genentech-Access.com/XOLAIR to enroll and manage your patients online.

Instructions: *All fields required.* Complete this form after each infusion/injection and fax completed form to GATCF at the number listed above or submit through My Patient Solutions.

Date of Service:	Amount Infused/Injected:	Date of Service:	Amount Infused/Injected:
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg
/ /	mg	/ /	mg

Please complete, sign and date the following statement. (REQUIRED)

Print Patient Name (Required): _____

Patient's Date of Birth (Required): _____

Authorized HCP Signature (Required)†: _____

Date of Signature (Required): _____

Next Scheduled Infusion (if applicable): _____

CERTIFICATION: By signing above, I certify that all information on this form is correct, and this patient has been infused/injected with product listed above. I know that GATCF could ask me for a copy of the patient's infusion/injection records for the purpose of an audit. I agree to provide a copy of the patient's infusion/injection records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the Confirmation of Infusion or Injection is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*Only BioOncology products, Rheumatology products and XOLAIR are supported by My Patient Solutions

†The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP)

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Genentech® Access to Care Foundation (GATCF)
Insurance Attestation – HCP Administered Drugs

Phone (800) 704-6614 - Fax (800) 704-6615

This form is required for each of your patient's insurances and will serve as proof that the patient's insurance company will not cover the prescribed XOLAIR® (omalizumab) for subcutaneous use therapy. This form should be completed once you have the outcome of the first level of appeal.

Check ALL box(es) that apply to your patient and fax to GATCF at the number listed above.

❑ My office received a first-level appeal denial and the initial claim or Prior Authorization (PA) denial is upheld.

Date of initial claim or PA denial: ____/____/____

Reason for initial claim or PA denial:_____

Date of first-level appeal denial: ____/____/____

Reason for first-level appeal denial:_____

❑ My office received a recoupment for date of service:____/____/____

Date of recoupment letter:____/____/____

Reason for recoupment:_____

❑ My office received a peer-to-peer denial.

Date of review:____/____/____

Reason denial:_____

❑ My patient has met the daily/yearly CAP for insurance coverage.

Date CAP was met:____/____/____

Date CAP reset:____/____/____

PLEASE NOTE: *If the patient's insurance denied coverage due to an administrative error, untimely filing or not following the insurance policy requirements, your patient does not meet GATCF insurance criteria. GATCF requires one level of appeal for patients to be considered rendered uninsured.*

Please complete, sign and date the following statement. (REQUIRED)

Authorized HCP Signature (Required): _____Date:_____

Print Physician First and Last Name: _____

Patient Insurance Company Name: _____

Print Patient's First and Last Name: _____

Patient's Date of Birth: _____

CERTIFICATION: By signing above, I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements.

I know GATCF could ask me for a copy of the patient's insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

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PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION (PAN)

Xolair Omalizumab FOR SUBCUTANEOUS USE | Access Solutions®

Phone: (800) 704-6610 **Fax:** (800) 704-6612 **Genentech-Access.com/XOLAIR**

ACS/092914/0051 10/14

XOLAIR Access Solutions is a free program for you from Genentech.

We work to help you pay for your Genentech product. We can help in many different ways. We assist people who have a health care plan as well as those who don't.

If you don't have a health care plan, or your plan won't pay for your Genentech product(s), we might be able to help. If you meet certain financial and medical standards, we can supply free medicine. This is done through the Genentech® Access to Care Foundation (GATCF).

For us to help, we need to look at, use and disclose your personally identifiable information (PII). Your health care provider and health care plan can disclose your PII to us only with your written authorization. By signing this authorization form, you are authorizing your health care provider and health care plan to release your PII to us, and authorizing us to disclose your PII as necessary to perform services for you. Once you sign this form and it is sent back to us, or submitted electronically by you or by your health care provider on your behalf, we can start to provide these services. You can choose not to agree to this authorization, however, please note that we cannot provide our services without it. This means you might need to pay for certain medications on your own.

PLEASE READ THROUGH THIS FORM CAREFULLY. IF YOU HAVE ANY QUESTIONS, TALK TO YOUR HEALTH CARE PROVIDER'S OFFICE OR CALL US AT THE PHONE NUMBER LISTED AT THE TOP OF THIS PAGE.

1 INFORMATION TO BE DISCLOSED OR USED

This signed form lets my health care providers and health care plans send my PII, and this form electronically, to Genentech Access Solutions and/or GATCF. This includes:

- All my health records relating to my treatment
- Information about my health care plan benefits
- The dollar balance left on the total of the lifetime payments covered by my health care plan policy (if this applies to my plan)
- Any information having a bearing on my health or my adherence to my treatment

All of the above is considered part of my PII. I know this could include information about:

- Sexually transmitted diseases
- Mental health conditions
- Genetic test results

2 WHO MAY SEE AND USE MY PII

My PII may be seen by Genentech Access Solutions and/or GATCF. These are programs sponsored by Genentech. Its address is 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. It may also be seen by anyone helping Genentech Access Solutions perform services, including Genentech employees and any of Genentech's partners, for the purpose of facilitating access to Genentech products. Genentech may share your PII with Sponsors, and/or their agents and affiliates, and your health care provider and health plan.

My PII may be used only in these ways:

- Helping with my health care plan coverage for Genentech products
- Applying to GATCF
- Determining eligibility for alternative forms of coverage and sources of funding
- Coordination of prescription fulfillment through a pharmacy
- Tracking my use of Genentech products
- For Genentech, or our partners' administrative purposes

3 NOTICES

This authorization and notice of release is in effect for 1 year from the date I signed it.

Once I sign this form, I know my PII might not be covered by any federal law that restricts the use and disclosure of my PII. There is no guarantee my PII might not be released to a third party. This third party might not need to follow the conditions of this authorization and notice of release.

I know I can refuse to sign this form. I may withdraw authorization at any time and for any reason. This won't affect the start or continuing of my treatment, the quality of my treatment, and will have no impact on my treatment by my health care provider. To withdraw it, I must send a written notice to Genentech. It can be sent by fax or by mail to the address on this page. This withdrawal goes into effect once it is received by Genentech. If I don't sign this form or if I withdraw my authorization, Genentech will not be able to help me with access to my Genentech product(s).

I understand that I, as the patient or signer, have a right to obtain a copy of this signed authorization and notice of release during the one year it is valid, and up to three years after it is signed.

4 DISTRIBUTION ACCEPTANCE

If I receive free product from GATCF, I will use Genentech products as my health care provider has prescribed them to me. I will not sell or distribute Genentech products. I understand it is unlawful to do this. I am responsible for ensuring any Genentech product is sent to a secure address when it is shipped to me. I know it is my duty to control any Genentech product while it stays in my possession.

This written notice must be signed, dated, and mailed, faxed, or electronically submitted to

Genentech Access Solutions
1 DNA Way, Mail Stop #858a
South San Francisco, CA 94080-4990

Fax: (800) 704-6612

5 SIGNATURE AND DATE (REQUIRED)

I have read this document or have had it explained to me. By signing this form, I know I am authorizing the release and disclosure of my PII as discussed in this authorization form. **Please fill in all information below. Be sure to sign and date this form. If you don't, it could hold up the process for helping you.**

You must sign and date here

_____ _____ _____

Signature of Patient or Legally Authorized Person | Relationship to Patient | Date Signed

You must print your name here

_____ _____

Print Patient's Name | Patient/Alternate Contact Address

If signing for the patient you must print your name here

_____ _____

Legally Authorized Person/Alternate Contact Name | Contact Phone

☐ OK to leave a detailed message*: I authorize Genentech Access Solutions/GATCF to leave a detailed message at the following number: _____

*I understand this message may include PII, including but not limited to, the name of the medication I have been prescribed, my doctor's name, and details regarding insurance coverage

6 FINANCIAL INFORMATION (GATCF ONLY)

TOTAL HOUSEHOLD INCOME FOR THE PREVIOUS CALENDAR YEAR: $ _____

Read the following attestation: I understand that to qualify for free medicine, GATCF has criteria that must be met, including income. I certify the above statement of my total annual household income for the previous calendar year is true, and I do not have the financial resources or insurance coverage to pay for Genentech products. I know that GATCF could ask me for a copy of my IRS 1040 form or other proof of income for the purpose of an audit. I agree to provide my financial documentation in a timely manner, if so requested. In addition, I will notify GATCF immediately if my insurance situation changes. Please note that GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the financial attestation is false or inaccurate. By signing this attestation, I certify that the above statement of my annual household income amount is true and accurate, to the best of my knowledge.

Sign and date here (Required for GATCF Enrollment)

_____ _____

Signature of Patient or Legally Authorized Person | Date Signed

7 AN OPTIONAL AND FREE PATIENT SUPPORT PROGRAM

I want to enroll in an optional and free patient support program from Genentech. I understand my PII is needed for me to be a part of this program. I also know my PII will be shared with Genentech Access Solutions and the patient support program. I may choose to be contacted by mail, email or phone. I understand my PII won't be shared outside of Genentech, or by its agents. I agree to let Genentech or its agents contact me in the future about this program.

The Genentech privacy policy can be found at Genentech-Access.com. I understand I do not have to sign this part of the form. It plays no role in getting my medicine. It is not part of receiving help from Genentech Access Solutions. I also know I may cancel this enrollment in the patient support program at any time. To cancel, I can call (877) 436-3683.

Preferred way to contact me (Please check the box that applies and fill in your information. You can check more than one box.):
☐ Email: _____ ☐ Phone Number: _____ Okay to leave a message? ☐ Yes ☐ No
☐ Address: _____

Choose to enroll by signing here

_____ _____

Signature of Patient/Legally Authorized Person (You must sign here to enroll in the patient support program) | Date Signed

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AUTORIZACIÓN DEL PACIENTE Y AVISO DE DIVULGACIÓN DE INFORMACIÓN (PAN)

Teléfono: (800) 704-6610 **Fax:** (800) 704-6612 **Genentech-Access.com/XOLAIR**

ACS/091814/0034(1) 10/14

XOLAIR Access Solutions es un programa gratuito de Genentech para usted.

Trabajamos para ayudarlo a pagar su producto de Genentech. Podemos ayudarlo de muchas maneras diferentes. Ayudamos a las personas que cuentan con un plan de salud y a quienes no lo tienen.

Si no tiene plan de salud, o si su plan no pagará por su(s) producto(s) de Genentech, es posible que podamos ayudarlo. Si cumple con ciertos estándares financieros y médicos, podemos proporcionarle el medicamento en forma gratuita. Esto se hace a través de la Genentech® Access to Care Foundation (GATCF).

Para ayudarlo, necesitamos ver, usar y revelar su información personal identificable (personally identifiable information, PII). Su proveedor de atención médica y su plan de salud pueden revelarnos su PII únicamente con su autorización por escrito. Al firmar este formulario de autorización, usted autoriza a su proveedor de atención médica y a su plan de salud a entregarnos su PII, y nos autoriza a revelar su PII según sea necesario para proporcionarle servicios. Una vez que firme este formulario y este se nos envíe de regreso, o usted o su proveedor de atención médica en su nombre nos lo envíen electrónicamente, podemos empezar a proporcionarle estos servicios. Usted puede optar por no acceder a esta autorización, sin embargo, tenga en cuenta que no podemos proporcionarle nuestros servicios sin ella. Esto significa que podría ser necesario que pague ciertos medicamentos por su propia cuenta.

LEA CUIDADOSAMENTE ESTE FORMULARIO. SI TIENE PREGUNTAS, HABLE CON EL CONSULTORIO DE SU PROVEEDOR DE ATENCIÓN MÉDICA O LLÁMENOS AL NÚMERO TELEFÓNICO QUE APARECE EN LA PARTE SUPERIOR DE ESTA PÁGINA.

1 INFORMACIÓN QUE SE REVELARÁ O USARÁ

Este formulario firmado les permite a mis proveedores de atención médica y planes de salud enviar mi PII, y este formulario en forma electrónica, a Genentech Access Solutions y/o a la GATCF. Esto incluye:

- Todos mis registros médicos relacionados con mi tratamiento
- Información sobre los beneficios de mi plan de salud
- El saldo en dólares que queda del total de los pagos de por vida que cubre la póliza de mi plan de salud (si esto se aplica a mi plan)
- Toda información relacionada con mi salud o el cumplimiento de mi tratamiento

Todo lo mencionado arriba se considera parte de mi PII. Sé que esto podría incluir información sobre:

- Enfermedades de transmisión sexual
- Afecciones de salud mental
- Resultados de pruebas genéticas

2 QUIÉN PUEDE VER Y USAR MI PII

Mi PII puede ser vista por Genentech Access Solutions y/o la GATCF. Estos son programas que patrocina Genentech. Su dirección es 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. También puede ser vista por cualquier persona que ayude a Genentech Access Solutions en la prestación de servicios, lo que incluye a empleados de Genentech y a cualquier socio de Genentech, a los efectos de facilitar el acceso a los productos de Genentech. Genentech puede compartir su PII con los Patrocinadores, y/o sus agentes y afiliadas, y con su proveedor de atención médica y plan de salud.

Mi PII se puede usar solamente de las maneras siguientes:

- Ayudarme con la cobertura de mi plan de salud para productos de Genentech
- Presentar una solicitud a la GATCF
- Determinar la elegibilidad para formas de cobertura y fuentes de financiamiento alternativas
- Coordinación del surtido de recetas a través de una farmacia
- Rastrear mi uso de productos de Genentech
- Para fines administrativos de Genentech o de nuestros socios

3 AVISOS

Esta autorización y aviso de divulgación tiene vigencia durante 1 año a partir de la fecha en que la firmé.

Una vez que firme este formulario, sé que mi PII podría no estar cubierta por las leyes federales que restringen el uso y la divulgación de mi PII. No existe ninguna garantía de que mi PII no se revele a un tercero. Es posible que este tercero no necesite cumplir con las condiciones de esta autorización y aviso de divulgación.

Sé que puedo negarme a firmar este formulario. Puedo retirar la autorización en cualquier momento y por cualquier razón. Esto no afectará el inicio ni la continuación de mi tratamiento, tampoco afectará la calidad de mi tratamiento, ni tendrá efecto alguno en el tratamiento que me brinda mi proveedor de atención médica. Debo enviar un aviso por escrito a Genentech para retirarla. Puedo enviarlo por fax o por correo postal a la dirección que se muestra en esta página. Este retiro entra en vigencia una vez que Genentech lo recibe. Si no firmo este formulario o si retiro mi autorización, Genentech no podrá ayudarme con el acceso a mi(s) producto(s) de Genentech.

Comprendo que, como paciente o firmante, tengo derecho a obtener una copia de esta autorización y aviso de divulgación firmada durante el año en que tenga validez, y hasta tres años después de que se firme.

4 ACEPTACIÓN DE DISTRIBUCIÓN

Si recibo productos gratuitos de la GATCF, usaré los productos de Genentech como mi proveedor de atención médica me los recetó. No venderé o distribuiré los productos de Genentech. Entiendo que es ilegal hacerlo. Soy responsable de asegurarme de que cualquier producto de Genentech se envíe a una dirección segura cuando me hagan el envío. Sé que es mi deber controlar cualquier producto de Genentech mientras esté en mi poder.

Este aviso por escrito se debe firmar, fechar y enviar por correo postal, fax o en forma electrónica a:

Genentech Access Solutions
1 DNA Way, Mail Stop #858a
South San Francisco, CA 94080-4990

Fax: (800) 704-6612

5 FIRMA Y FECHA (OBLIGATORIAS)

He leído este documento o me lo han explicado. Al firmar este formulario, sé que estoy autorizando la divulgación y entrega de mi PII como se analiza en este formulario de autorización **Complete toda la información a continuación. Asegúrese de firmar y fechar este formulario. Si no lo hace, se podría retrasar el proceso para brindarle ayuda.**

Debe firmar y colocar la fecha aquí _____ _____ _____
Firma del Paciente o de la Persona Legalmente Autorizada | Relación con el Paciente | Fecha de la Firma

Debe poner aquí su nombre, en letra de imprenta _____ _____
Nombre del Paciente, en Letra de Imprenta | Dirección del Paciente/Contacto Alternativo

Si firma por el paciente, debe poner aquí su nombre, en letra de imprenta _____ _____
Nombre de la Persona Legalmente Autorizada/Nombre del Contacto Alternativo | Teléfono del Contacto

☐ Se puede dejar un mensaje detallado*: Autorizo a Genentech Access Solutions/la GATCF a dejar un mensaje detallado en el siguiente número: _____

*Comprendo que este mensaje puede incluir PII, lo cual comprende, pero no se limita a, el nombre del medicamento que se me recetó, el nombre de mi médico y detalles relativos a la cobertura de seguro

6 INFORMACIÓN FINANCIERA (GATCF ÚNICAMENTE)

INGRESOS FAMILIARES TOTALES CORRESPONDIENTES AL AÑO CALENDARIO PREVIO: $ _____

Lea el testimonio siguiente: Comprendo que para reunir los requisitos a fin de recibir medicamentos gratuitos, la GATCF tiene ciertos criterios que se deben cumplir, lo que incluye los ingresos. Certifico que mi declaración anterior de los ingresos familiares totales correspondientes al año calendario previo es verdadera, y que no cuento con recursos económicos ni cobertura de seguro para pagar los productos de Genentech. Sé que la GATCF podría solicitarme una copia de mi formulario 1040 del IRS u otra prueba de mis ingresos para propósitos de auditoría. Estoy de acuerdo con proporcionar en forma oportuna mis documentos financieros, si me los solicitan. Además, notificaré inmediatamente a la GATCF si cambia mi situación de seguro. Tenga en cuenta que la GATCF ejercerá todos los recursos legales apropiados, lo que incluye un juicio de indemnización por daños y perjuicios en litigio, en el caso de que la GATCF determine que esta certificación es falsa o que el testimonio financiero es falso o inexacto. Al firmar este testimonio, certifico que el monto de mis ingresos familiares anuales declarados arriba es verdadero y exacto, a mi leal saber y entender.

Firme y coloque la fecha aquí (Se requiere para la Inscripción en la GATCF) _____ _____
Firma del Paciente o de la Persona Legalmente Autorizada | Fecha de la Firma

7 UN PROGRAMA OPCIONAL Y GRATUITO DE ASISTENCIA AL PACIENTE

Deseo inscribirme en un programa opcional y gratuito de asistencia al paciente brindado por Genentech. Entiendo que se necesita mi PII para que pueda participar en este programa. También sé que se compartirá mi PII con Genentech Access Solutions y con el programa de asistencia al paciente. Puedo elegir que se me contacte por correo, correo electrónico o teléfono. Entiendo que mi PII no será compartida fuera de Genentech, ni por sus agentes. Acepto que Genentech o sus agentes se pongan en contacto conmigo en el futuro sobre este programa.

La política de privacidad de Genentech se puede encontrar en Genentech-Access.com. Entiendo que no tengo que firmar esta parte del formulario. No tiene ningún efecto a la hora de obtener mi medicamento. No forma parte de recibir asistencia de Genentech Access Solutions. También sé que puedo cancelar esta inscripción en el programa de asistencia al paciente en cualquier momento. Para cancelar, puedo llamar al (877) 436-3683

Forma preferida de ponerse en contacto conmigo (Marque el casillero que corresponda y complete su información. Puede marcar más de un casillero.):

☐ Correo electrónico: _____ ☐ Número de teléfono: _____ ¿Se puede dejar un mensaje? ☐ Sí ☐ No
☐ Dirección: _____

Elija inscribirse firmando aquí _____ _____
Firma del Paciente o de la Persona Legalmente Autorizada (Debe firmar aquí para inscribirse en el programa de asistencia al paciente) | Fecha de la Firma

Genentech BioOncology®, su logotipo y el logotipo de Access Solutions son marcas comerciales registradas de Genentech, Inc

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STATEMENT OF MEDICAL NECESSITY (SMN) FOR XOLAIR

Phone: (800) 704-6610 Fax: (800) 704-6612
Genentech-Access.com/XOLAIR

Xolair Omalizumab FOR SUBCUTANEOUS USE | Access Solutions®

XOL0002290501 03/14

IMPORTANT INFORMATION: This SMN cannot be fully processed without a signature and date. Please complete all required sections and include a signed and dated PAN form. Providing additional documents or information with this form, other than what is requested, will delay processing.

Please write legibly and complete all required fields (*) to prevent delays

SERVICES REQUESTED

- Check the appropriate services requested XOLAIR Access Solutions and/or Genentech® Access to Care Foundation (GATCF) cannot perform services without the healthcare professional's specific authorization

INSURANCE INFORMATION

- Include legible copies of the patient's insurance card(s)
- This section should include both primary and secondary insurance to ensure that ALL potential coverage can be explored
- Include all sources of insurance coverage, including Medicare and Medicaid if eligible

PRESCRIBER INFORMATION

- Complete this section to ensure timely insurance review. Note that the office address listed here does not have to match the DEA or Medical License number addresses

DIAGNOSIS AND CLINICAL INFORMATION

- Check (and fill in, if applicable) the appropriate ICD-9-CM code to the highest level of specificity
- Check the appropriate boxes to provide information about past and current therapies for the appropriate indication

Lab Results (for appropriate patients with allergic asthma)

- Include on the form whether the patient has had a positive skin test or radioallergosorbent test (RAST)
- Indicate the patient's pretreatment serum IgE level in the field provided

PRESCRIPTION INFORMATION

- Check the appropriate box to indicate the prescription type
- Be sure to check the correct dosage. The specialty pharmacy is not permitted to calculate this on its own and will not fill a prescription without it
- To avoid multiple callbacks from the specialty pharmacy, you must indicate the quantity dispensed and the number of refills
- XOLAIR must be stored (ie, refrigerated) at 2°C–8°C [36°F–46°F]

ACQUISITION AND ADMINISTRATION

- Indicate whether a specialty pharmacy or Buy and Bill is required
- Provide information about the place of administration, including Tax ID number

XOLAIR STARTER PROGRAM

- To request a starter supply of XOLAIR for a patient, please check the appropriate box on page 3 and indicate the correct dosage
- Payers may not be billed for XOLAIR Starter supply
- For eligibility criteria, please visit Genentech-Access com/XOLAIR and/or speak to your XOLAIR representative

Complete and submit this form online via My Patient Solutions™, our online patient management tool. Visit Genentech-Access.com/XOLAIR to register for My Patient Solutions.

STATEMENT OF MEDICAL NECESSITY (SMN) FOR XOLAIR

Please write legibly and complete all required fields (*) to prevent delays

Phone: (800) 704-6610 Fax: (800) 704-6612
Genentech-Access.com/XOLAIR

Xolair Omalizumab FOR SUBCUTANEOUS USE | Access Solutions®

XOL0002290501 03/14

SERVICES REQUESTED*
(check only those that apply)

☐ **Benefits Investigation/Prior Authorization** ☐ **Appeals Support**
☐ **GATCF† Patient Assistance** ☐ **Co-pay Assistance**

PATIENT INFORMATION

Last name*: _____ **First name*:** _____
Birth date*: _____ **Gender*:** ☐ Male ☐ Female
Street _____
City: _____ **State*:** _____ ZIP: _____
Home phone (____) _____ Work/cell phone: (____) _____
Email _____
Alternate contact last name _____ First name: _____
Phone (____) _____ Relationship to patient: _____
OK to contact patient? ☐ Yes ☐ No

INSURANCE INFORMATION

Include all sources of insurance coverage, including Medicare and Medicaid, and drug card if eligible and provide legible copies of all cards (front/back)

Does patient have insurance? ☐ Yes ☐ No Did patient have a change of insurance? ☐ Yes ☐ No
Insurance card(s) attached? ☐ Yes ☐ No Does the patient have drug card(s)? ☐ Yes ☐ No

Primary insurance (PI) name: _____
☐ HMO ☐ PPO ☐ Medicare/Medicaid
Name of IPA/medical group _____
PI phone _____
PI subscriber name: _____
Subscriber date of birth: _____
PI subscriber ID #: _____
Policy/group # _____
Relationship to patient: _____

Secondary insurance (SI) name: _____
☐ HMO ☐ PPO ☐ Medicare/Medicaid
Name of IPA/medical group: _____
SI phone _____
SI subscriber name _____
Subscriber date of birth. _____
SI subscriber ID #: _____
Policy/group #: _____
Relationship to patient _____

PRESCRIBER INFORMATION

Practice name: _____
Prescriber's last name*: _____ **First name*:** _____
Street*: _____
City*: _____ **State*:** _____ ZIP: _____
Prescriber tax ID _____ Prescriber NPI‡: _____
DEA #*: _____ Group NPI: _____
State license #: _____
Office contact last name _____ First name _____
Office contact phone. (____) _____ Fax: (____) _____
Office Email: _____

***Required field.** †Genentech® Access to Care Foundation ‡National Provider Identifier

Complete and submit this form online via My Patient Solutions™, our online patient management tool.
Visit Genentech-Access.com/XOLAIR to register for My Patient Solutions.

DIAGNOSIS/CLINICAL INFORMATION

FOR APPROPRIATE PATIENTS WITH ALLERGIC ASTHMA

ICD-9-CM*: ☐ 493 00 Extrinsic asthma, unspecified ☐ 493 90 Asthma, unspecified type, unspecified
☐ 493 20 Chronic obstructive asthma, unspecified ☐ Other ICD-9-CM _____

(Complete to the highest level of specificity)

Pretreatment serum IgE level IU/mL (1 0 kU/L=1 0 IU/mL, 2 4 ng/mL=1 0 IU/mL)

IgE level _____ Test date _____ Patient weight _____ kg Weight date _____

☐ History of positive skin or RAST test to a perennial aeroallergen

☐ Moderate to severe allergic persistent asthma

ER visits/hospitalizations ☐ Date(s) _____

Unscheduled office visits ☐ Date(s) _____

FEV_1 (if available) _____%

Other asthma therapies

Short-acting beta-agonist (SABA)	☐ Current	☐ Past
Inhaled corticosteroids (ICS without LABA)	☐ Current	☐ Past
Long-acting beta-agonist (LABA without ICS)	☐ Current	☐ Past
Combination therapy (ICS/LABA)	☐ Current	☐ Past
Oral and/or injectable steroids	☐ Current	☐ Past
Other (specify) _____	☐ Current	☐ Past

FOR APPROPRIATE PATIENTS WITH CIU

ICD-9-CM*: ☐ 708 1 Idiopathic urticaria
☐ 708 8 Other specified urticaria
☐ 708 9 Urticaria, unspecified
☐ Other ICD-9-CM _____

(Complete to the highest level of specificity)

☐ Patient has had CIU for 6 weeks or more

Other CIU therapies

☐ H1 antihistamines
☐ Other _____

PRESCRIPTION INFORMATION

Prescription type: Naive/new start ☐ Restart ☐ Continued Tx ☐ Last injection date _____ **Drug allergies:** _____

FOR APPROPRIATE PATIENTS WITH ALLERGIC ASTHMA

Quantity dispensed*: ☐ 30-day supply ☐ 90-day supply

☐ Diluent 10-mL vial preservative-free sterile water for injection, USP, ancillary supplies 3-mL syringes as needed for reconstitution, 18-gauge needles as needed for reconstitution, 25-gauge needles as needed for administration

Prescription: Dispense XOLAIR subcutaneously

SIG ☐ 150 mg/dose every 4 weeks SIG ☐ 300 mg/dose every 4 weeks
SIG ☐ 225 mg/dose every 2 weeks SIG ☐ 300 mg/dose every 2 weeks
SIG ☐ 375 mg/dose every 2 weeks

Refill _____ times

FOR APPROPRIATE PATIENTS WITH CIU

Quantity dispensed*: ☐ 30-day supply ☐ 90-day supply

☐ Diluent 10-mL vial preservative-free sterile water for injection, USP, ancillary supplies 3-mL syringes as needed for reconstitution, 18-gauge needles as needed for reconstitution, 25-gauge needles as needed for administration

Prescription: Dispense XOLAIR subcutaneously

SIG ☐ 150 mg/dose every 4 weeks SIG ☐ 300 mg/dose every 4 weeks

Refill _____ times

ACQUISITION AND ADMINISTRATION

Dispensing of XOLAIR through. ☐ Specialty Pharmacy ☐ Buy and Bill

Preferred specialty pharmacy _____

Place of administration: ☐ Physician's office ☐ HOPD‡ ☐ Alternate injection center **Ship to** ☐ Physician's office ☐ HOPD ☐ Alternate injection center

Place of administration name _____ Place of administration tax ID _____

Address _____

XOLAIR STARTER PROGRAM

For eligibility criteria, please visit Genentech-Access.com/XOLAIR and/or speak to your XOLAIR representative

XOLAIR Starter Program Prescription ☐ Dispense 28-day XOLAIR Starter supply refill§ x2 subcutaneously

FOR APPROPRIATE PATIENTS WITH ALLERGIC ASTHMA

SIG ☐ 150 mg/dose every 4 weeks SIG ☐ 300 mg/dose every 4 weeks
SIG ☐ 225 mg/dose every 2 weeks SIG ☐ 300 mg/dose every 2 weeks
SIG ☐ 375 mg/dose every 2 weeks

FOR APPROPRIATE PATIENTS WITH CIU

SIG ☐ 150 mg/dose every 4 weeks SIG ☐ 300 mg/dose every 4 weeks

*Required field. †Chronic Idiopathic Urticaria ‡Hospital Outpatient Department §Refills will be provided only upon receipt of the Injection Attestation Form

By signing below, I certify that (a) the above therapy is medically necessary, (b) I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc , Novartis Pharmaceuticals Corporation ("the Companies"), XOLAIR Access Solutions and contracted dispensing pharmacy or other contractors for the purpose of seeking reimbursement, assisting in initiating or continuing therapy and/or the evaluation of the patient's eligibility for the XOLAIR Starter Program and the Genentech® Access to Care Foundation related to the Companies' products, as a break in treatment would negatively impact the patient's therapeutic outcome, (c) I will not sell or bid for any free product received in my office for patients from the XOLAIR Starter Program and I will not attempt to seek reimbursement for free or replacement product provided directly to the patient or for the dates of service for which free or replacement product was provided and (d) I appoint XOLAIR Access Solutions solely to convey on my behalf to the pharmacy chosen by the above-named patient the prescription described herein

I agree to comply with the program guidelines as established by Genentech, Inc and understand that Genentech, Genentech Access to Care Foundation and XOLAIR Access Solutions, at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of the information submitted I further understand that Genentech will provide vial replacement in a configuration that will create the least amount of wastage

Sign and date

X _____ _____

Prescriber Signature* **Date***

This form cannot be processed without an original or stamped signature Please include a signed and dated Patient Authorization and Notice of Release of Information form

Print patient's name here

Patient last name*: _____ **First name***: _____ **Date of birth***: _____

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Genentech® Access to Care Foundation (GATCF)
Insurance Attestation – Patient-Administered Drugs

Phone (800) 530-3083 - Fax (877) 428-2326

This form is required for each of your patient's insurances and will serve as proof that the patient's insurance company will not cover the prescribed ZELBORAF® (vemurafenib) therapy. Complete this form when the outcome for any situations listed below has been met.

Check ALL box(es) that apply to your patient and fax to GATCF at the number listed above.

- ☐ My office received an initial claim denial or Prior Authorization (PA) denial.
  - Date of initial claim denial or PA denial: _____/_____/_____
  - Reason for denial: _____
- ☐ My office has submitted for a first-level appeal.
  - Date appeal letter submitted: _____/_____/_____
- ☐ My office received a first-level appeal denial.
  - Date of appeal denial letter: _____/_____/_____
  - Reason for denial: _____
- ☐ My office received a peer-to-peer denial.
  - Date of review: _____/_____/_____
  - Reason for denial: _____
- ☐ My patient has met the daily/yearly CAP for insurance coverage.
  - Date CAP was met: _____/_____/_____
  - Date CAP reset: _____/_____/_____

PLEASE NOTE: *If the patient's insurance denied coverage due to an administrative error, untimely filing or not following the insurance policy requirements, your patient does not meet GATCF insurance criteria. GATCF requires one level of appeal for patients to be considered rendered uninsured.*

Please complete, sign and date the following statement. (REQUIRED)

Authorized HCP Signature (Required)*: _____ Date: _____

Print Physician First and Last Name: _____

Patient Insurance Company Name: _____

Print Patient's First and Last Name: _____

Patient's Date of Birth: _____

CERTIFICATION: By signing above, I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements.

I know GATCF could ask me for a copy of the patient's insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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