

SUBMIT ONLY REQUESTED DOCUMENTS

Required field (\*)

## Step 1 Patient Information

### SERVICES REQUESTED

(check all that apply):

**Benefits Investigation (BI) and Prior Authorization (PA) Support**

Re-verify benefits at PA expiration

**Co-pay Referrals**

- Genentech Co-pay Card
- Co-pay Assistance Foundation

**Appeals Support**

If you believe your patient is eligible for free medicine, call Genentech Patient Foundation at (888) 941-3331.

\*FIRST NAME: \_\_\_\_\_ \*LAST NAME: \_\_\_\_\_

\*DATE OF BIRTH (MM/DD/YYYY): \_\_\_\_ / \_\_\_\_ / \_\_\_\_ \*GENDER:  MALE  FEMALE

\*STREET: \_\_\_\_\_ APT: \_\_\_\_\_

\*CITY: \_\_\_\_\_ \*STATE: \_\_\_\_\_ \*ZIP: \_\_\_\_\_

PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ PHONE TYPE:  CELL  HOME

DO NOT CONTACT PATIENT EMAIL: \_\_\_\_\_

PATIENT-PREFERRED LANGUAGE:  ENGLISH  SPANISH  OTHER: \_\_\_\_\_

ALTERNATE CONTACT NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ ALT PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

## Step 2 Insurance Information

Please fill out the information below or attach insurance card(s).

Is the patient insured?  Yes  No

See copy of insurance card(s)

Is PA in place?  Yes  No AUTH #: \_\_\_\_\_

	PRIMARY INSURANCE	SECONDARY INSURANCE	PHARMACY BENEFIT
INSURANCE NAME			
SUBSCRIBER NAME (if not patient)			
SUBSCRIBER ID			
POLICY/GROUP #			
INSURANCE PHONE #			

## Step 3 Patient's Therapy (check all that apply)

### Infused and Subcutaneous (SC) Therapy

- Avastin® (bevacizumab)
- GAZYVA® (obinutuzumab)
- Herceptin® (trastuzumab)
- Herceptin HYLECTA™ (trastuzumab and hyaluronidase-oysk)
- KADCYLA® (ado-trastuzumab emtansine)
- PERJETA® (pertuzumab)
- PHESGO™ (pertuzumab/trastuzumab/hyaluronidase-zzxf)
- POLIVY™ (polatuzumab vedotin-piiq)
- RITUXAN® (rituximab)
- RITUXAN HYCELA® (rituximab/hyaluronidase human)
- TECENTRIQ® (atezolizumab)

### Oral Therapy (complete prescription on page 3)

- ALECENSA® (alectinib)
- COTELLIC® (cobimetinib)
- Erivedge® (vismodegib)
- GAVRETO® (pralsetinib)
- ROZLYTREK® (entrectinib)
- XELODA® (capecitabine)  
For XELODA requests, attach prescription
- ZELBORAF® (vemurafenib)

List medications used in combination with Genentech therapy for a regimen benefits investigation.

See attached medication list REGIMEN NAME: \_\_\_\_\_

MEDICATIONS/DOSING OR BILLING CODES: \_\_\_\_\_


### Where will infused or subcutaneous medication(s) be administered?

Physician's office  HOPD†  Other (please specify): \_\_\_\_\_

NAME: \_\_\_\_\_

TAX ID #: \_\_\_\_\_ NPI‡ ID #: \_\_\_\_\_

Medication(s) dispensed through:  Buy and bill  Onsite pharmacy  Specialty pharmacy (SP): \_\_\_\_\_

 Please continue to Step 4 on the next page

†Hospital outpatient department. ‡National Provider Identifier.

SUBMIT ONLY REQUESTED DOCUMENTS

Required field (\*)

## Step 4 Patient Information (please re-enter)

\*FIRST NAME: \_\_\_\_\_ \*LAST NAME: \_\_\_\_\_ \*DOB (MM/DD/YYYY): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Step 5 Diagnosis and Clinical Information

To the highest level of specificity, provide:

*PRIMARY DIAGNOSIS CODE: _____	HER2 positive? <input type="checkbox"/> Yes <input type="checkbox"/> No
SECONDARY DIAGNOSIS CODE: _____	PD-L1 positive? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has the patient started therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No      Date of Treatment: ____ / ____ / ____	Neo-adjuvant: <input type="checkbox"/> Yes <input type="checkbox"/> No
Line of therapy: <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Other: _____	Adjuvant: <input type="checkbox"/> Yes <input type="checkbox"/> No
Clinical TNM stage:	Previous treatment:
<input type="checkbox"/> 0 <input type="checkbox"/> IIA <input type="checkbox"/> IIIA <input type="checkbox"/> IIIC	<input type="checkbox"/> None <input type="checkbox"/> Radiation <input type="checkbox"/> Hormone therapy <input type="checkbox"/> Surgery
<input type="checkbox"/> 1 <input type="checkbox"/> IIB <input type="checkbox"/> IIIB <input type="checkbox"/> IV	<input type="checkbox"/> Other (if chemotherapy, please specify): _____

## Step 6 Prescriber Information

\*FIRST NAME: \_\_\_\_\_ \*LAST NAME: \_\_\_\_\_

\*PRACTICE NAME: \_\_\_\_\_

\*STREET: \_\_\_\_\_ SUITE: \_\_\_\_\_

\*CITY: \_\_\_\_\_ \*STATE: \_\_\_\_\_ \*ZIP: \_\_\_\_\_

PRESCRIBER TAX ID #: \_\_\_\_\_ PRESCRIBER NPI ID #: \_\_\_\_\_ GROUP NPI ID #: \_\_\_\_\_

OFFICE CONTACT: \_\_\_\_\_ OFFICE CONTACT EMAIL: \_\_\_\_\_

OFFICE CONTACT PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ OFFICE CONTACT FAX: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

## Step 7 Health Care Provider Certification

By submitting this form, I certify:

- (a) The above therapy is medically necessary for this patient and the treatment decision has been made by the prescribing physician.
- (b) If the indication for which this Genentech product is being prescribed to treat is not listed in the FDA-approved label, the prescriber is prescribing the medication for an “unapproved” use, meaning that the FDA has not approved the efficacy, dosage amount or safety of this medication for such a use.
- (c) The provider’s office received the authorization to release the information above and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc., Genentech Access Solutions, the contracted dispensing pharmacy, or other contractors for the purpose of requesting reimbursement support, assisting in initiating or continuing therapy, as a break in treatment would negatively impact the patient’s therapeutic outcome.
- (d) The provider’s office will not attempt to seek reimbursement for free product provided to the patient.
- (e) The services requested on behalf of the patient may include benefits investigation (BI), benefits re-verification, prior authorization (PA) and appeals support, co-pay card and co-pay assistance foundation referral. In the absence of a checkbox selecting a service, Genentech Access Solutions will perform BI/PA services on behalf of the patient.
- (f) No action on these services will be taken until the patient consent document has been received.**



- If you are seeking support for Infused or SC therapy, fax pages 1 and 2 to (888) 249-4919
- If you are seeking support for Oral or Starter therapy, please continue to page 3

RITUXAN® and RITUXAN HYCELA® are registered trademarks of Biogen. ALECENSA® is a registered trademark of Chugai Pharmaceutical Co., Ltd., Tokyo, Japan. GAVRETO® is discovered by Blueprint Medicines and co-commercialized by Genentech with Blueprint Medicines Corporation in the US. GAVRETO is a trademark of Blueprint Medicines Corporation. Avastin®, GAZYVA®, Herceptin®, Herceptin HYLECTA™, KADCYLA®, PERJETA®, PHESGO™, TECENTRIQ®, COTELLIC®, Erivedge®, ZELBORAF®, POLIVY™, ROZLYTREK®, and XELODA®, the Genentech logo, and the Access Solutions logo are registered trademarks of Genentech, Inc.

©2021 Genentech USA, Inc. So. San Francisco, CA All rights reserved.

SUBMIT ONLY REQUESTED DOCUMENTS

ORAL PRODUCTS ONLY - Complete all fields for prescribed therapy

## Step 8 Patient Information (please re-enter)

\*FIRST NAME: \_\_\_\_\_ \*LAST NAME: \_\_\_\_\_ \*DOB (MM/DD/YYYY): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Step 9 Prescription Information

**For ALECENSA® (alectinib) patients**

Metastatic non-small cell lung cancer (NSCLC)?  Yes  No  
 Positive for anaplastic lymphoma kinase (ALK)?  Yes  No

**Prescription**  600 mg twice daily  Other: \_\_\_\_\_  
 DISPENSE: \_\_\_\_\_-MONTH SUPPLY REFILL: \_\_\_\_\_ TIMES

**ALECENSA SureStart® free starter supply**  600 mg twice daily  
 DISPENSE: 1-MONTH SUPPLY  REFILL: 1 TIME

**For Erivedge® (vismodegib) patients**

Metastatic basal cell carcinoma?  Yes  No  
 Locally advanced basal cell carcinoma recurred following surgery, or not a candidate for surgery, and not a candidate for radiation?  Yes  No

**Prescription**  150 mg daily  Other: \_\_\_\_\_  
 DISPENSE: \_\_\_\_\_-MONTH SUPPLY REFILL: \_\_\_\_\_ TIMES

**For COTELLIC® (cobimetinib) patients**

Unresectable/metastatic melanoma?  Yes  No  
 Used in combination with ZELBORAF® (vemurafenib)?  Yes  No  
 (If yes, complete ZELBORAF section to the right)

**Prescription**  60 mg daily for 21 consecutive days on, followed by a 7-day rest period  
 Other: \_\_\_\_\_

DISPENSE: \_\_\_\_\_-MONTH SUPPLY REFILL: \_\_\_\_\_ TIMES

Confirmed positive for BRAF V600E?  Yes  No  
 Confirmed positive for BRAF V600K?  Yes  No

**For ROZLYTREK® (entrectinib) patients**

Metastatic non-small cell lung cancer (NSCLC)?  Yes  No  
 Positive for ROS1?  Yes  No  
 Positive for neurotrophic tropomyosin receptor kinase (NTRK) fusions without a known acquired resistance?  Yes  No

**Prescription**  600 mg daily  Other: \_\_\_\_\_  
 DISPENSE: \_\_\_\_\_-MONTH SUPPLY REFILL: \_\_\_\_\_ TIMES

**SureStart free starter supply**  600 mg once daily  Other: \_\_\_\_\_  
 DISPENSE: 1-MONTH SUPPLY  REFILL: 1 TIME

**For XELODA® (capecitabine) patients** Attach prescription

**For GAVRETO® (pralsetinib) patients**

Rearranged during transfection (RET) fusion-positive metastatic non-small cell lung cancer (mNSCLC)?  Yes  No  
 Advanced or metastatic RET-mutant medullary thyroid cancer (MTC)?  Yes  No  
 Advanced or metastatic RET fusion-positive thyroid cancer?  Yes  No

**Prescription**  400 mg once daily  Other: \_\_\_\_\_  
 DISPENSE: \_\_\_\_\_-MONTH SUPPLY REFILL: \_\_\_\_\_ TIMES

**GAVRETO SureStart® free starter supply**  400 mg once daily  Other: \_\_\_\_\_  
 DISPENSE: 1-MONTH SUPPLY  REFILL: 1 TIME

**For ZELBORAF® (vemurafenib) patients**


Unresectable/metastatic melanoma?  Yes  No  Other  
 Confirmed positive for BRAF V600E?  Yes  No

**Prescription**  960 mg twice daily for 21 days, 720 mg twice daily thereafter  
 960 mg twice daily  
 Other: \_\_\_\_\_

DISPENSE: \_\_\_\_\_-MONTH SUPPLY REFILL: \_\_\_\_\_ TIMES

## Step 10 Prescriber Certification

**By signing this form, I certify:** (a) The above therapy is medically necessary for this patient and the treatment decision has been made by the prescribing physician. (b) If the indication for which you are prescribing a Genentech product is not listed in the FDA-approved label, you are prescribing the medication for an “unapproved” use, meaning that the FDA has not approved the efficacy, dosage amount or safety of this medication for such a use. (c) I received the authorization to release the information above and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc., Genentech Access Solutions, the contracted dispensing pharmacy, or other contractors for the purpose of requesting reimbursement support, assisting in initiating or continuing therapy, as a break in treatment would negatively impact the patient’s therapeutic outcome and (d) I will not attempt to seek reimbursement for free product provided to the patient. I request Genentech Access Solutions convey to the pharmacy chosen by the above-named patient the prescription described herein. (e) The services you are requesting on behalf of the patient, may include benefits investigation (BI), benefits re-verification, prior authorization support (PA), co-pay card and co-pay assistance foundation referral. In the absence of a checkbox selecting a service, we will perform BI/PA services on behalf of the patient. **(f) No action on these services will be taken until the patient consent document has been received.** (g) For prescribers in states with official prescription form requirements, such as New York, prescriptions must be submitted on an official state prescription pad along with this enrollment form.

 Sign, date & fax to (877) 313-2659 \*Prescriber’s Signature: \_\_\_\_\_ \*Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 (Original or stamped signature required)

Required field (\*)