

Step 1 Patient Information

*First name: _____ *Last name: _____
 *Date of birth (MM/DD/YYYY): ____/____/____ Gender: ☐ Male ☐ Female
 Street: _____ Apt: _____
 City: _____ *State: _____ ZIP: _____
 Phone: (____) ____-____ ☐ Cell ☐ Home ☐ Do not contact patient
 Email: _____ Preferred language: ☐ English ☐ Spanish ☐ Other: _____
 Alternate contact name: _____ Relationship: _____ Phone: (____) ____-____

Step 2 Insurance Information

Is the patient insured? ☐ Yes ☐ No
 **If patient is uninsured, please complete the Prescriber Foundation Enrollment Form [here](#) or call (888) 941-3331 for assistance.**
If insured, please fill out the information below or attach a copy of the patient's health insurance cards.
 Is prior authorization in place? ☐ Yes ☐ No Authorization #: _____

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

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

☐ GAZYVA® (obinutuzumab) intravenous (IV) infusion Infuse 1000 mg ☐ Weeks 1, 2, 24, and 26 ☐ Every 6 months ☐ Other: _____ ☐ Dispense GAZYVA vials: ____ 1000-mg dose Refill ____ times	☐ Rituxan® (rituximab) intravenous (IV) infusion SIG: Infuse: ____ mg ☐ Day 1 and Day 15 ☐ Once a week for 4 weeks ☐ Other: _____ ☐ Dispense Rituxan vials: ____ 100-mg dose ____ 375-mg dose ____ 500-mg dose Refill ____ times	☐ ACTEMRA® (tocilizumab) intravenous (IV) infusion SIG: Infuse: ____ mg ☐ Once every 2 weeks ☐ Once every 4 weeks ☐ Other: _____ ☐ Dispense ACTEMRA vials: ____ 80-mg dose ____ 200-mg dose ____ 400-mg dose Patient weight: ____ lb Refill ____ times	☐ ACTEMRA® (tocilizumab) subcutaneous (SC) self-injectable ☐ Prefilled syringe ☐ Autoinjector (ACTPen®) Inject 162 mg ☐ Once a week ☐ Once every 2 weeks ☐ Other: _____ Dispense: ☐ 1 month ☐ 2 months ☐ 3 months ☐ Other: _____ Patient weight: ____ lb Refill ____ times
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Step 4 Diagnosis and Clinical Information

To the highest level of specificity, provide:
 *Primary diagnosis code: _____ Anticipated date of treatment: ____/____/____
 Secondary diagnosis code: _____ Has the patient started therapy? ☐ Yes ☐ No

Step 5 Acquisition and Administration Information

Specialty pharmacy needed for GAZYVA, Rituxan, or ACTEMRA dispensing? ☐ Yes ☐ No (Place of infusion will supply)
 Preferred specialty pharmacy: _____
Place of infusion: ☐ Physician's office ☐ Hospital outpatient ☐ Infusion center ☐ Other: _____
 Infusion site name: _____ Infusion site tax ID #: _____
 Infusion site NPI† #: _____ Street: _____ Suite: _____
 City: _____ State: _____ ZIP: _____

†National Provider Identifier.

Step 6 Patient Information (please re-enter)

*First name: _____ *Last name: _____ *Date of birth (MM/DD/YYYY): ____ / ____ / ____

Step 7 Prescriber Information

*First name: _____ *Last name: _____

*Practice name: _____

*Street: _____ Suite: _____ *City: _____

*State: _____ *ZIP: _____ Prescriber tax ID #: _____

☐ Rheumatologist ☐ Nephrologist ☐ Other specialty

Prescriber NPI† #: _____ Group NPI† #: _____ Prescriber email: _____

Office contact: _____ Contact phone: (_____) _____ - _____ Contact fax: (_____) _____ - _____

If you are a resident of a US state that provides certain rights with respect to your personal information, a complete description of the personal information we may collect and process, the purposes for which it is used by Genentech, and your rights under your state's privacy laws concerning your personal information can be found in our privacy notice at www.gene.com/privacy-policy.

†National Provider Identifier.

Step 8 GAZYVA, Rituxan, and ACTEMRA Immunology Co-pay Program Enrollment Criteria

☐ By checking this box, I certify that:

- I have the patient's consent to enroll in the GAZYVA® (obinutuzumab), Rituxan® (rituximab), or ACTEMRA® (tocilizumab) Immunology Co-pay Program for assistance with drug out-of-pocket costs and/or Genentech GAZYVA, Rituxan, or ACTEMRA administration out-of-pocket costs
- The patient is not using and I will not bill any federal or state-funded healthcare program. This includes, but is not limited to, Medicare, Medicaid, Medigap, VA, DoD, and TRICARE
- The patient is not currently receiving Genentech GAZYVA, Rituxan, or ACTEMRA drugs from the Genentech Patient Foundation
- The patient is not currently receiving assistance from any other charitable organization for any of their out-of-pocket costs that are covered by the GAZYVA, Rituxan, and ACTEMRA Immunology Co-pay Program
- Genentech reserves the right to rescind, revoke, or amend the program without notice at any time
- I have read and accepted the full GAZYVA Program Terms and Conditions as found on the following link:
GAZYVAimmunologycopay.com/hcp/terms-and-conditions
- I have read and accepted the full Rituxan and ACTEMRA Program Terms and Conditions as found on the following link:
RACopay.com/hcp/terms-and-conditions

Step 9 Healthcare Provider Certification



BY SUBMITTING THIS FORM:

I am requesting services on behalf of the patient, which may include benefits investigation and reverification, help navigating the prior authorization process, and appeals support

By submitting this form, I certify: (a) The above therapy is medically necessary for this patient and the treatment decision has been made by the prescribing physician. (b) If the indication for which this Genentech product is being prescribed to treat is not listed in the FDA-approved label, the prescriber is prescribing the medication for an "unapproved" use, meaning that the FDA has not approved the efficacy, dosage amount, or safety of this medication for such a use. (c) The provider's office received the authorization to release the information above and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to Genentech, Inc., Genentech Access Solutions, the contracted dispensing pharmacy, or other contractors for the purpose of requesting reimbursement support, assisting in initiating or continuing therapy, as a break in treatment would negatively impact the patient's therapeutic outcome. (d) 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), prior authorization (PA) and appeals support, co-pay program referral or enrollment, and co-pay assistance foundation referral. (f) **No action on these services will be taken until the patient consent document has been received.**