Genentech
A Member of the Roche Group
Access Solutions

for GAZYVA® (obinutuzumab), Rituxan® (rituximab) & ACTEMRA® (tocilizumab)

Immunology Prescriber Service Form

SUBMIT ONLY REQUESTED DOCUMENTS

Required field (*) **M-US-00006696(v6.0)**

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
☐ Infuse 20 mg/kg

☐ Weeks 0, 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

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: _____

☐ **Please provide assistance locating a treatment site for patient**

Infusion site name: _____ Infusion site tax ID #: _____

Infusion site NPI #: _____ Street: _____ Suite: _____

City: _____ State: _____ ZIP: _____

NPI=National Provider Identifier.

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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 #: _____ 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**.

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 health care 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 Health Care 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)** Medical Necessity: The prescribed therapy is medically necessary and the treatment decision was made by the prescribing physician. **(b)** FDA Status: If the medication is prescribed for a use not on the FDA-approved label, I acknowledge the FDA has not approved the efficacy, dosage or safety for such non-indicated use. **(c)** PHI Authorization: My office has received authorization to release the patient's protected health information (PHI) to Genentech and its partners to assist with reimbursement and therapy initiation. **(d)** Reimbursement: My office will not attempt to seek reimbursement for free product provided to the patient. **(e)** Service Request: I am requesting services including benefits investigation, prior authorization, appeals support and co-pay referrals. **(f)** Consent and Compliance: No action will be taken until patient consent is received. I will comply with all state-specific prescription requirements (e.g., e-prescribing, specific forms).

FDA=US Food and Drug Administration; NPI=National Provider Identifier.

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