

# Genentech® Access to Care Foundation (GATCF) STATEMENT OF MEDICAL NECESSITY (SMN)



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

Phone: (866) 247-5084 Fax: (800) 305-1830

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

<input type="checkbox"/> HMO/EPO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Indemnity <input type="checkbox"/> Medicare/Medicaid <input type="checkbox"/> PBM <input type="checkbox"/> Pending Medicaid <input type="checkbox"/> No insurance Insurance denial/non-coverage policy attached? <input type="checkbox"/> Yes <input type="checkbox"/> No Primary insurance (PI) name: _____ PI phone: _____ PI subscriber name: _____ PI subscriber ID #: _____ Policy/group #: _____ Insurance card attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> HMO/EPO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Indemnity <input type="checkbox"/> Medicare/Medicaid <input type="checkbox"/> PBM <input type="checkbox"/> Pending Medicaid <input type="checkbox"/> No insurance Insurance denial/non-coverage policy attached? <input type="checkbox"/> Yes <input type="checkbox"/> No Secondary insurance (SI) name: _____ SI phone: _____ SI subscriber name: _____ SI subscriber ID #: _____ Policy/group #: _____ Insurance card attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
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DIAGNOSIS/TREATMENT

**DIAGNOSIS (highest level of specificity)\*:**  Human Immunodeficiency virus (HIV) disease (042)  Other: Specify by ICD-9-CM: \_\_\_\_\_  
 Has patient started prescribed therapy?  Yes  No If so, last treatment date: \_\_\_\_\_  
 Medical rationale for prescribing medication: \_\_\_\_\_  
 Please list any other medications the patient is currently taking: \_\_\_\_\_  
 NKDA or  Allergies: \_\_\_\_\_

PRESCRIPTION

<p><b>► For FUZEON® (enfuvirtide) Patients Only</b></p> Dose: _____ mg Dispense: <input type="checkbox"/> 90-mg/mL convenience pack <input type="checkbox"/> 30-day supply <input type="checkbox"/> 60-day supply <input type="checkbox"/> 90-day supply Refill: _____ times (max refills is 11 per month) <b>SIG:</b> _____ Please send this supply of medication to (if not indicated, order will ship to patient's address): <input type="checkbox"/> Patient address: _____ <input type="checkbox"/> Physician/hospital address: _____	<p><b>► For INVIRASE® (saquinavir mesylate) Patients Only</b></p> Dose: _____ mg Dispense: <input type="checkbox"/> 200-mg capsules <input type="checkbox"/> 500-mg capsules <input type="checkbox"/> 30-day supply <input type="checkbox"/> 60-day supply <input type="checkbox"/> 90-day supply Refill: _____ times (max refills is 11 per month) <b>SIG:</b> _____ Please send this supply of medication to (if not indicated, order will ship to patient's address): <input type="checkbox"/> Patient address: _____ <input type="checkbox"/> Physician/hospital address: _____
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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 labels for FUZEON and INVIRASE before prescribing. If the indication for which you are prescribing FUZEON or INVIRASE is not listed in the label, you are prescribing FUZEON or INVIRASE for an "unapproved" use. The fact that the use for which you are prescribing FUZEON or INVIRASE is not listed in the FDA-approved label indicates that the FDA has not approved the efficacy, dosage amount or safety of FUZEON or INVIRASE when used for such a use. Nevertheless, GATCF will consider providing FUZEON or INVIRASE 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., GATCF 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\*:** \_\_\_\_\_

(Original signature required. This form cannot be processed without a prescriber's signature.)

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

# Genentech® Access to Care Foundation (GATCF) STATEMENT OF MEDICAL NECESSITY (SMN)

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

## 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

## 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/TREATMENT

- Check the appropriate Diagnosis Code
- If "Other" is checked, specify the ICD-9-CM code to the highest level of specificity using the 3-, 4- or 5-digit code

## PRESCRIPTION

**Please indicate the prescribed therapy [FUZEON® (enfuvirtide) or INVIRASE® (saquinavir mesylate)]**

- Complete the dose and refill fields along with the dispense instructions

## PRESCRIBER

- Stamped prescription signatures are not accepted

## GATCF REQUIRED FIELDS

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

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

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