Patient Authorization and Notice of Request for Transmission of Health Information to Genentech Access Solutions and Genentech® Access to Care Foundation (PAN)

ACS/092914/0045(2) 01/17

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

Genentech Access Solutions works to help you understand how to pay for your Genentech product. 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 products, Genentech might be able to help. If you meet certain criteria, we can supply free medicine. This is done through the Genentech Access to Care Foundation (GATCF).

Genentech Access Solutions and GATCF take patient privacy seriously. We recognize that your health information is sensitive and take steps to protect it and keep it confidential. In order for Genentech Access Solutions to help you, we will need to look at, use, and disclose some of your personally identifiable information (PII) including health information. By signing this form, you are directing your health care provider and health care plan to transmit certain PII to us and you are authorizing us to use and further disclose your PII as necessary to assist you. Once you sign this form and it is sent back to us, or it is submitted electronically by you or your health care provider on your behalf, we can start assisting you. You can choose not to sign this form; however, please note that we cannot assist you without it.

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 that may be used or disclosed

I am directing my health care provider(s) and/or health care plan(s) to share the following information with Genentech Access Solutions and/or GATCF:

- Health information related to my treatment with Genentech products, including relevant diagnoses and prescriptions
- Information about my health care plan benefits, including my deductibles and anticipated annual and lifetime out-of-pocket costs

2 Who may see and use my PII

I authorize Genentech Access Solutions and/or GATCF to use and further disclose my PII to Agents, affiliates and vendors who are assisting Genentech Access Solutions and/or GATCF; and my health care provider(s), health care entities, pharmacies and health plan(s) for the purpose of facilitating my access to Genentech products, including:

- Coordinating with my health care plan for understanding coverage for Genentech products
- Applying to GATCF
- Determining my eligibility for alternative forms of coverage and sources of funding for my Genentech medicines
- Coordinating fulfillment of my prescription through a pharmacy
- For administrative purposes that support Genentech Access Solutions and GATCF

3 Notices

This PAN shall be in effect for 3 years from the date of my signature, or the date of last enrollment, whichever comes first, unless a shorter period is required by law.

I understand that if I am a resident of the state of Maryland, this authorization will be valid for no longer than 1 year from the date I signed it.

Once I sign this PAN form and my PII is transmitted to Genentech Access Solutions and/or GATCF, I understand that the Health Insurance Portability and Accountability Act (HIPAA) may no longer protect the PII disclosed to Genentech Access Solutions and/or GATCF by my health care provider or others covered by the HIPAA laws because Genentech Access Solutions and GATCF are not covered by HIPAA. I understand that Genentech Access Solutions and GATCF are committed to protecting my information and keeping it secure and confidential while it is being collected or used to assist me and that the use and disclosure of my information will be limited to that described above.

I understand that I can refuse to sign this PAN form. I also understand that I can cancel this PAN form at any time and for any reason. I understand that this cancellation means that Genentech Access Solutions and/or GATCF will no longer use or share my PII, but does not apply to PII already used or shared. To cancel this PAN form, I must send a written notice to Genentech. It can be sent by fax or by mail to the address on this page. If I cancel this PAN form, I understand that Genentech Access Solutions and GATCF will no longer be able to assist me with access to my Genentech product(s).

The address for Genentech Access Solutions and GATCF is 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. The fax number for Genentech Access Solutions and GATCF is (866) 827-8188.

I understand that I, as the patient or signer, have a right to obtain a copy of this signed PAN form during the period it is in effect.

4 Distribution acceptance

If I receive free product from GATCF, 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.

Section 5 on the next page is required.
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) 827-8188

5 Signature and date

(Required in order to obtain the assistance of Genentech Access Solutions and the Genentech Access to Care Foundation)*

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.

Required:

Print patient name

Last Name | First Name | Date of Birth

Signature of Patient or Legally Authorized Person | Date Signed

Print name of person signing (if not the patient)

Last Name | First Name | Relationship to Patient

Optional:

☐ **OK to leave a detailed message†:**

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

*If an error is made, the person signing the PAN form must correct the information by putting a single line through the mistake and initialing it. Rewrite the correct information next to the mistake. Other forms of correction, such as crossing out words or white-out will not be accepted.

†By providing my phone number, I authorize Genentech to use auto-dialers, prerecorded messages, and artificial voice messages to contact me. I understand that these calls/texts may mention the name of Genentech products or services, details about my insurance coverage, and my doctor's name. I understand that I am not required to consent to being contacted by phone or text message as a condition of any purchase of Genentech products or enrollment in Genentech Access Solutions or GATCF.

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.

Choose to enroll by signing and dating here

Signature of Patient or Legally Authorized Person | Date Signed

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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

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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 Pt. preferred language (if other than English): ______

INSURANCE

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

Insurance denial/non-coverage policy attached? ☐ Yes ☐ No

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

Insurance denial/non-coverage policy attached? ☐ Yes ☐ No

Secondary insurance (SI) name: ____________

SI phone: ____________

SI subscriber name: ____________

SI subscriber ID #: ____________

Policy/group #: ____________

Insurance card attached? ☐ Yes ☐ No

DIAGNOSIS/TREATMENT

DIAGNOSIS CODE (highest level of specificity)*: ☐ B20 Human Immunodeficiency Virus (HIV) disease ☐ Other: ____________

Has patient started prescribed therapy? ☐ Yes ☐ No If so, last treatment date: ____________

Please list any other medications the patient is currently taking: ____________

☐ NKDA or ☐ Allergies: ____________

____

PRESCRIPTION

For FUZEON® (enfuvirtide) Patients Only

Dose: ______ mg

Dispense: 90-mg/mL convenience pack

30-day supply 60-day supply 90-day supply

Refill: ______ times (max refills is 11 per month)

SIG: ____________

For INVIRASE® (saquinavir mesylate) Patients Only

Dose: ______ mg

Dispense: 200-mg capsules 500-mg capsules

30-day supply 60-day supply 90-day supply

Refill: ______ times (max refills is 11 per month)

SIG: ____________

Please send this supply of medication to (if not indicated, order will ship to patient's address):

Patient address: ____________ Physician/hospital address: ____________

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: (______) ____________

PHYSICIAN CERTIFICATION: By signing below, I certify: (a) the above therapy is medically necessary, (b) 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, infusion site of care or other contractors for the purpose of requesting reimbursement support, 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 and (c) I will not attempt to seek reimbursement for free product provided directly to the patient or an alternative site of care. I request Genentech Access Solutions convey to the pharmacy or alternative site of administration chosen by the above-named patient the prescription described herein. I agree to comply with the Genentech, Inc. program guidelines and understand that Genentech and GATCF, at its sole 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 wastage. If applying for GATCF, I certify that (a) this patient has no medical insurance coverage or otherwise meets the financial criteria for the prescribed therapy, and is not eligible for other product financial support programs, and (b) the therapy identified above will not be used in a clinical trial. Note: Prescribers in all states must follow applicable law for a valid prescription and who is considered an authorized prescriber. For prescribers in states with official prescription form requirements, such as New York, please submit prescriptions on an official state prescription blank along with this form. Unapproved Use Warning: Please read the FDA-approved label for Genentech products before prescribing. 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 when used for such a use. Nevertheless, GATCF will consider providing the medication for your patient with this admonition, based upon your medical order, within program requirements

Prescriber's Signature*: ____________________ Date*: ____________

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

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

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

DIAGNOSIS/TREATMENT

- Check the appropriate Diagnosis Code
- If "Other" is checked, specify the diagnosis code to the highest level of specificity
- For dates of service prior to October 1, 2015, ICD-9-CM codes must be used. For dates of service on or after October 1, 2015, only ICD-10-CM codes will be accepted

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

ATTACH TO COMPLETED SMN

- Attach signed and dated Patient Authorization and Notice of Release of Information (PAN), Insurance Attestation, Patient Financial Attestation, and Confirmation of Infusion forms. GATCF cannot work on your patient's behalf without these signed and dated forms

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.

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

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