Genentech | ACCESS SOLUTIONS®
A Member of the Roche Group

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

M-US-00002896(v1.0) 01/20

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

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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

Some of these disclosures may constitute a sale of PII. If so, I have the right to opt out of the sale of my PII if I reside in California. Additional information regarding my privacy rights can be found on Genentech's website privacy policy (www.gene.com/privacy-policy).

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. If I reside in California, I also have the right to request that Genentech Access Solutions and/or GATCF delete my PII, although deletion is not required under certain circumstances. To cancel this PAN form or request deletion of my PII, 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 and request deletion of my PII, 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

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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:	Optional:

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 _____

☐ **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. Message and data rates may apply.

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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