

Genentech® Access to Care Foundation (GATCF) for FUZEON® (enfuvirtide)

Statement of Medical Necessity (SMN)

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

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

M-US-00006697(v1.0) 08/20

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 Preferred language (if other than English): _____

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 CODE (highest level of specificity)*: B20/042 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

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: _____
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.)

*Required field. [†]No known drug allergies. [‡]National Provider Identifier. [§]Drug Enforcement Administration. [¶]Provider Transaction Access Number.

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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

- 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) for FUZEON. 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.

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