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

☐ 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)*: ☐ B20/042 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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