

Statement of Medical Necessity for Genentech BioOncology

Phone: (888) 249-4918 Fax: (888) 249-4919 Web: BioOncologyAccessSolutions.com

Genentech
BIOONCOLOGY™

Access Solutions™
Treatment made possible.™

Services Requested (Check All That Apply)

Please complete with a ballpoint pen.

- Benefits Investigation Insurance Prior Authorization
 Appeals Assistance Co-pay Assistance GATCF Eligibility Screening

Patient Information

Last Name: _____ First Name: _____
Date of Birth (MM/DD/YYYY): _____ Male Female
Street: _____
City: _____ State: _____ ZIP: _____
Primary phone: _____
Secondary phone: _____
Is it OK to contact patient? Yes No
Alternate contact: _____
Relationship: _____
Alternate contact primary phone: _____
Alternate contact secondary phone: _____
Is patient deceased? Yes No

Insurance Information

Is the patient currently insured? Yes No
Is the patient eligible for Medicaid? Yes No Pending
Copy of insurance card (front and back) attached: Yes No
Primary Insurance Name: _____
Phone: _____
Subscriber: _____
Subscriber ID #: _____
Group #: _____
Employer: _____ Retired
Copy of insurance card (front and back) attached: Yes No
Secondary Insurance Name: _____
Phone: _____
Subscriber: _____
Subscriber ID #: _____
Group #: _____
Employer: _____ Retired

Clinical Trial Patient

Clinical Trial Patient? Yes No

If Yes, Study Site: _____
Study #: _____
Clinical Coordinator: _____
Phone: _____

Facility/Physician Profile

Facility/Group Name: _____
Physician's Full Name: _____
Specialty: Oncologist Other (specify) _____
Street: _____
City: _____ State: _____ ZIP: _____
Office Hours: _____
Clinical/Medical Contact: _____
Phone: _____ Fax: _____
Reimbursement Contact: _____
Phone: _____ Fax: _____
Group Tax ID #: _____
Physician's Tax ID #: _____
Facility NPI* #: _____
Physician NPI #: _____
Facility PTAN† #: _____ Physician PTAN #: _____
DEA #: _____
MD License #: _____
Medicare #: _____
Medicaid #: _____
Blue Cross/Blue Shield #: _____

Patient Medical Information

Indicate Patient's Therapy (Check All That Apply):

- AVASTIN® (bevacizumab) Herceptin® (trastuzumab)
 Rituxan® (rituximab) Tarceva® (erlotinib)

Has Treatment Started? Yes No

If Yes, Date of First Treatment: _____

Place of Administration:

- Physician's Office Hospital Outpatient Hospital Inpatient

Primary ICD-9 Code: _____ Description: _____
(required)

Secondary ICD-9 Code: _____ Description: _____

Date of Diagnosis: _____

Clinical TNM Stage:

- 0 I IIA IIB IIIA IIIB IIIC IV

Metastatic Site(s):

- Adrenals Brain Bone Liver Lung Lymph Nodes Ovaries
 Peritoneal Cavity Other (please specify) _____

Previous Treatment:

- None Bone Marrow Transplant
 Chemotherapy (please specify) _____
 Hormone Therapy Immunotherapy Oral Radiation
 Radio-labeled antibodies (please specify) _____
 Surgery Other (Please specify) _____

*National Provider Identifier. †Provider Transaction Access Number.

Patient Information

Last Name: _____ First Name: _____ Date of Birth (MM/DD/YYYY): _____

Patient Medical Information (Cont.)

Number of Doses Planned: _____ Dose: _____ mg

Frequency of Administration: _____

Concurrent Treatment Prescribed With Genentech Product: _____

If applicable, HER2 Positive? Yes No

Test Results _____ % _____ 1+ _____ 2+ _____ 3+ Other _____

Adjuvant: Yes No

UNAPPROVED USE WARNING: Please read the FDA-approved label for Genentech BioOncology products before prescribing. If the indication for which you are prescribing a Genentech BioOncology product is not listed in the label, you are prescribing the medication for an "unapproved" use. The fact that the use for which you are prescribing this medication is not listed in the FDA-approved label indicates that the FDA has not approved the efficacy, dosage amount or safety of the medication when used for such a use. **Nevertheless, the Genentech® Access to Care Foundation (GATCF) will consider providing the medication for your patient with this admonition, based upon your medical order, within program requirements.**

For Rituxan Patients Only

Disease Characteristics:

Indolent Aggressive CD20 Positive

For Tarceva Patients Only

Tarceva (150-mg, 100-mg or 25-mg tablets)

New Start Continuing Therapy

150 mg daily 100 mg daily Other _____ mg daily

Dispense: 30-day supply Refill: _____ times

Shipping Instructions

Shipping address same as the Facility/Physician address? Yes No

If no, please complete the remainder of this section.

Facility/Group Name: _____

DEA #: _____

License #: _____

Street (Street address required, no PO boxes): _____

City: _____ State: _____ ZIP: _____

Contact Name: _____

Phone: _____ Fax: _____

Certification Statements

- 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., Genentech BioOncology Access Solutions 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, and (c) I appoint Genentech BioOncology Access Solutions solely to convey on my behalf to the pharmacy chosen by the above-named patient the prescription described herein
- I further certify that I will not attempt to seek reimbursement for free/replacement product provided directly to the patient or for dates of service for which free/replacement product was provided
- I agree to comply with the program guidelines as established by Genentech USA, Inc
- If applying for GATCF, I certify that this patient has no medical insurance coverage for the pharmaceutical identified above and is not eligible for other public health insurance programs

Prescriber Signature

Date

(Original signature required—stamped signature will not be accepted)

Instructions for Use

Use this form to enroll all insured and uninsured patients needing Genentech BioOncology Access Solutions assistance.

Services Requested

Indicate all Genentech BioOncology Access Solutions services that you would like performed.

Check GATCF Eligibility Screening if you would like a pre-treatment check against the GATCF medical and financial criteria for your *insured* patients.

Clinical Trial Patient

Please complete if your patient is currently involved in a clinical trial.

Insurance Information

Please check the appropriate boxes to reflect the patient's insurance status.

For Rituxan Patients Only

Please check the appropriate box(es) to indicate the disease characteristics.

For Tarceva Patients Only

Please complete the prescription information for Tarceva® (erlotinib).

Shipping Instructions

Indicate where you would like the product to be shipped if the patient meets the required medical and income criteria.

Attach the Following to a Completed Enrollment Form:

A signed and dated Patient Authorization and Notice of Release of Information (PAN) form.

A front and back copy (enlarged and legible) of the patient's insurance card. For Tarceva patients, please provide a front and back copy of the patient's drug card.

If your claim or prior authorization submission has been denied, include a copy of the denial letter.

Reminder: Genentech BioOncology Access Solutions cannot work with the insurance plan on your patient's behalf without a physician's signature and date, as well as a signed and dated PAN form.

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